Top Nursing Calls

Internal Medicine Chief Residents 2020-2021

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Outline

- Initial steps for an unstable patient
- Types of codes
- Unstable Patient Scenarios
- COVID-19 Tips
- Other Patient Scenarios

Is the patient stable?

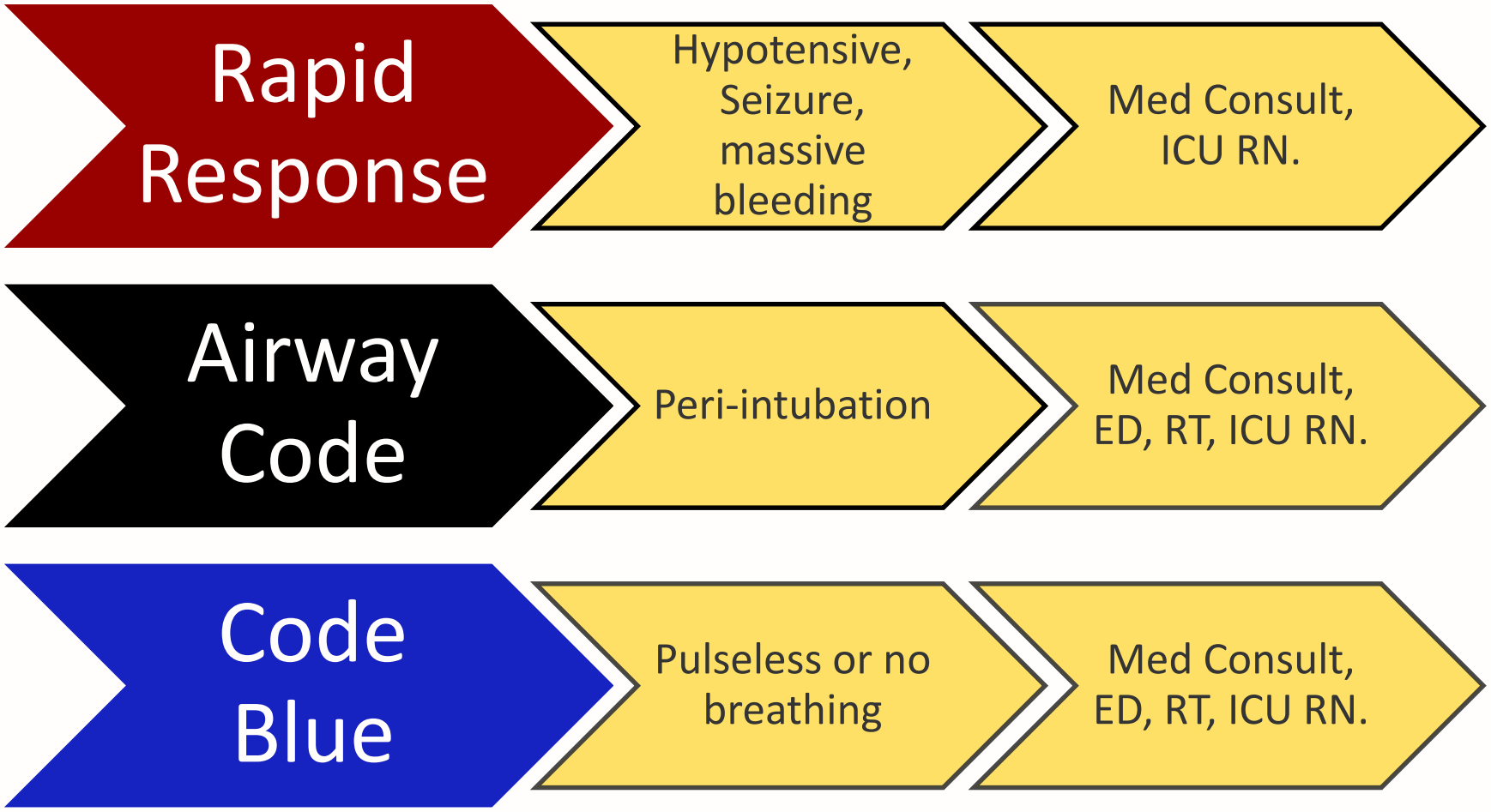
- Ask for vitals
- Do they have a pulse?
- Are they responsive?
- Are they protecting their airway?
- Are they bleeding?

Remember: it’s better to overreact than underreact if you are not sure.

If the patient is NOT stable…

- **Take a deep breath**
- Call for the crash cart
- Call your senior
- Call ANY senior
- Call Med Consult (x91644 < **memorize this**)
- If patient is pulseless, call a **CODE BLUE (Med consult, ICU RN's, RT's, ED code resident)**
- If a patient is unstable (but not pulseless), call a **Rapid Response** (Med Consult, ICU RN's, and RT's will arrive)
- If the patient needs to be intubated, call an **Airway Code** (ED will arrive for intubation)
- Order rainbow labs (CBC, CMP, Mg, Phos, PT/INR, Troponin, Type & Screen) and ABG
- Order an EKG and CXR
- Put in orders for where the patient should be transferred: Telemetry, PCU, ICU, etc.

Unstable Patient Scenarios



Unstable Patient Scenarios

Rapid Response	52 yo F moaning and altered in her bed. She is breathing, protecting her airway but very lethargic, you check a set of vitals and BP 70/40.
Code Blue	40 yo M h/o IV drug abuse, you find him down not breathing but with a faint pulse.
Airway Code	70 yo F with CHF, she is on Bipap in the PCU but become altered and tachypenic, she looks like he may “tire out” soon and is becoming confused.
Airway Code or RR	25 yo M admitted for ETOH withdrawal, begins seizing while you are examining him

“Doctor, patient has chest pain….”

- ASK FOR A FULL SET OF VITALS
- Is this patient stable?
- The Scary 5: ACS, PE, dissection, pericarditis with tamponade, esophageal rupture
  - Less scary: GERD, anxiety, MSK pain
- Initial studies: EKG, CXR, troponin
- Try to find an old EKG or old CXR to look for dynamic changes

“Doctor, patient is short of breath….”

- ASK FOR A FULL SET OF VITALS
- Is this patient stable? Does the patient need to be intubated?
- Is this primarily a cardiac or pulmonary cause?
- Was the patient on DVT prophylaxis?
- Other causes: anemia, neuromuscular disease, anxiety
- Initial studies: CXR, ABG, ECG?
- Oxygen options:
  - Nasal Cannula (1-6 L/min): each liter approximately 4% above FiO2 20% (1 L ~24%, 2 L ~28%, etc.)
  - Simple facemask (5-8 L/min): 35-55% FiO2
  - Nonrebreather facemask (6-15 L/min): 60-90% FiO2
  - High Flow Nasal Cannula (PCU if Full Code, Med/Surg if DNR/DNI during COVID-19)
  - BiPAP (not if altered!)
- Consider: Albuterol/ipratropium? Antibiotics? Diuretics? Anticoagulation?

“Doctor, patient is hypotensive…”

- ASK FOR FULL SET OF VITALS
- Secure IV access, obtain 2 large bore IV, start fluids (unless cardiogenic shock)
- Assess the patient: Confused? Neurologic deficits? Chest pain? Decreased UOP? Bleeding? Fever? Touch the patient, feels pulses and cool extremities. Consider calling a rapid.
- Compare to baseline BP
- Recheck blood pressure; consider machine malfunction or incorrect cuff size if pt. appears stable
- O2, Trendelenberg position, fluids, antibiotics
- Review medications (BP, pain)? Review underlying conditions (cirrhotic, CHF)?
- Initial studies: CBC, CMP, Type and Screen, Coags (PT/INR and PTT),
  If also febrile: urine/blood cultures, lactate, procal, CXR

“Doctor, patient is hypertensive…”

- ASK FOR FULL SET OF VITALS
- Urgent action is NOT required unless you think the patient has hypertensive emergency
- HTN emergency should go the ICU or CCU.
- Assess the patient, see all patients who are symptomatic
- Assess for end-organ damage (eyes, neurologic deficits, CP, SOB, headache; elevated BUN/Cr, hematuria)
- Compare to baseline BP
- Recheck blood pressure; consider machine malfunction or incorrect cuff size.
- Consider possible causes Utox, ETOH withdrawal
- Exceptions: Permissive Hypertension in the setting of ischemic stroke (typically 48 hours post stroke)

Medications to Lower BP

- Oral Options: CCBs, beta-blocker, hydralazine, captopril, diuretics, nitrates, clonidine
  - CCB: Amlodipine 5-10mg, titrate q2-3 days, will takes 48-72 hours to reach effect.
  - Beta-Blockers: Carvedilol 3.125mg BID (CHF), Labetalol 100-800 TID (good for renal failure), Metoprolol succinate (CHF with reduced EF); avoid if patient bradycardic
  - Hydralazine: 10-25mg q8. OK for most, avoid in severe AS, avoid when tachycardic
  - Captopril: fast-acting PO option if unable to give BB or hydralazine
- IV Options:
  - Labetalol, Hydralazine
  - Nurses cannot give IV BP medications on the floor or in 8A but medications such as IV labetalol can be ordered and pushed by MD if monitored
  - If its your first time, ask your senior for help

“Doctor, patient has a fever…”

- ASK FOR FULL SET OF VITALS
- **Initial tests: blood cultures, UA with micro and cultures, +/- CXR, lactate, procal**
- Exam: lines, skin exam, decubitus ulcers
- Medication review
- Immunocompromised? Uh oh.
- Antipyretic agents: acetaminophen, cooling measures
  - Think about contraindications (relative or absolute) to antipyretics
- Review previous cultures
- Noninfectious causes: malignancy, autoimmune, NMS, serotonin syndrome, drug fever, EtOH withdrawal, blood-transfusion reactions, thrombus or embolus

“Doctor, patient’s finger stick is…”

- LOW (< 70)
  - If asymptomatic, give juice & snacks; recheck finger stick
  - If symptomatic (or very low), give 1 amp of D50 in addition to above, may need D5/D10 gtt
  - No IV access and can’t take PO? Give glucagon 1 mg IM
  - Adjust insulin regimen
  - Does this indicate sepsis?
  - Consider underlying conditions
- HIGH (> 180)
  - Correctional insulin (usually lispro)
  - Review current insulin regimen and what pt. has received recently or is scheduled to receive
  - Review fluids/medications
  - Does this indicate sepsis?
  - Assess for DKA/HONK

“Doctor patient is seizing…”

- ASK FOR FULL SET OF VITALS AND ASSESS THE PT.
- Place patient in left lateral decubitus position to protect the airway
  - Convulsive patients may need manual restraint to avoid injury or fall
- Intubation? Consider possible causes of seizure
- Initial studies: finger stick, CMP, Mg, Phos, ABG, UA and urine toxicology, EtOH, prolactin, head CT
- Seizure >2 min? Give ativan 2 mg IV, wait 2 minutes, then ativan 2 mg IV again, wait 2 minutes, then give fosphenytoin
- If no IV access: versed 10 mg IM x 1 or lorazepam
- Consider Neurology consult if unable to break the seizure

“Doctor, patient is altered…”

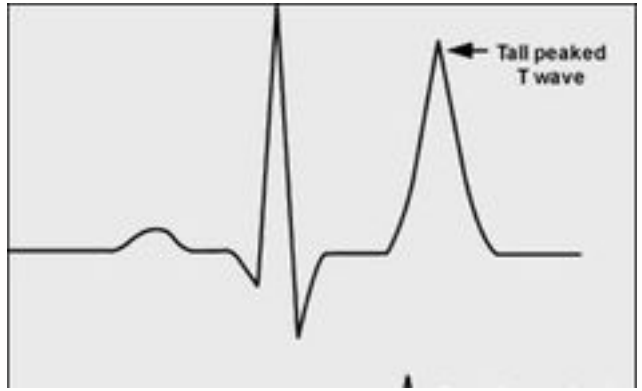
- ASK FOR FULL SET OF VITALS AND FOR CLARIFICATION AS TO WHAT IS MEANT BY ALTERED
- Evaluate for the scary stuff: sepsis, ICH/increased ICP, hypoxia, meningitis, delirium tremens, etc
- Review medications list
- If acute change, backtrack on recent events
- Get collateral history (nursing staff, family)
- Labs: finger stick, CBC, BMP/CMP, ABG, +/- CT Head, +/- UA with urine toxicology
- Delirium: minimize sedating medications, minimize restraints, sitter at bedside, frequent reorientation, sleep hygiene, antipsychotics (quetiapine)

“Doctor, patient has pain…”

- Scary pain? ASK FOR FULL SET OF VITALS
- Assess the patient and perform a physical exam
- Do not give NSAIDS (Ketoralac aka Toradol, Ibuprofen) to patients with renal failure, cirrhosis, ESRD, PUD/GI bleed, CHF
- Consider topical analgesics: warm/cold compresses, diclofenac gel, lidocaine cream
- Acetaminophen is OK in patients with liver disease (but no more than 2 g/day)
- Don’t forget about the acetaminophen component in Norco (hydrocodone-acetaminophen)!
- PO to IV – 3:1 for opiates
- Dilaudid (Hydromorphone) to Morphine – 5:1
- Opioids: renal or hepatic or age-dependent dosing
- Consider other causes of pain

“Doctor, patient is hyperkalemic…”

- Nurses get critical lab calls and will then inform you
- How high? Is this drastically different from previous?
  - Hemolysis, medications, pseudohyperkalemia
- EKG → if changes, give Ca gluconate
- Temporizing measures
  - Insulin + D50; insulin is IV (not subq)! Caution if patient is ESRD
  - Albuterol
  - Bicarbonate
- Does the patient pee? Diuretics
- Kayexalate (sodium polystyrene sulfonate) → avoid if patient has a bowel obstruction
- If requires urgent HD → call renal fellow, HD nurse. If needs transfer to ICU/PCU, call med consult



COVID-19 Management

DHS Expected Practices: Use of Medications in Patients with COVID-19 Disease

Found under “Rotator Resources” and “COVID-19” on our Chiefs’ Blog.

Reviews the use of corticosteroids, remdesivir, etc.

Expected Practice:

For outpatients with COVID-19 not requiring admission

- DHS continues to evaluate novel therapies for outpatient COVID-19 disease but does not recommend any specific therapy at this time.

For outpatients with COVID-19 requiring O2 supplementation for home

- Data is limited as to the benefits and risks of discharging a patient to complete a course of dexamethasone (or alternative steroid) for severe COVID-19. In the absence of data, providers should use their discretion as to whether they believe the benefits of such a strategy outweighs the risks for a given patient, such as the concerns for unmonitored blood pressure and blood glucose levels as an outpatient.

Patient hospitalized with COVID-19 not requiring oxygen

- No specific therapy is recommended at this time.

Patient hospitalized with COVID-19 requiring oxygen

- Corticosteroids are the preferred option for those receiving supplemental oxygen by high flow device, mechanical ventilation or extracorporeal mechanical oxygenation (ECMO), as recommended by NIH COVID-19 Guidelines, (Figure 1)
  - Use of steroids should be for up to 10 days or until stable for discharge, whichever comes first.

- Remdesivir is a preferred option for those with $SpO_2 \leq 94\%$ on ambient air (at sea level) or requiring supplemental oxygen via low flow device. There is insufficient data to recommend for or against use in patients using high flow oxygen, mechanical ventilation or ECMO (NIH COVID-19 Guidelines). (Figure 1)
  - Remdesivir should typically be given for 5 days, or until the time of hospital discharge, whichever comes first. Home IV therapy is not recommended.
  - Remdesivir should not be used in those with alanine transaminase or aspartate transaminase >5 times the upper limit of normal or calculated creatinine clearance of <30 mL/minute

DHS Expected Practices: Anticoagulation

Found under “Rotator Resources” and “COVID-19” on our Chiefs’ Blog.

Reviews use of anticoagulation and changir doses

Table 1: DHS Anticoagulation Guidelines for COVID-19 patients[1]

EXCLUSION CRITERIA: known bleeding diathesis, active bleeding, pre-existing coagulopathy, ascites (elevates baseline d-dimer), thrombocytopenia <50,000/mL[2]

CLINICAL CATEGORY			CONSIDER THE FOLLOWING	
LEVEL 1:				
NO VTE	**and**	D-dimer < 6.0 mcg/ml FEU	**CrCl≥ 30 ml/min**	**CrCl<30ml/min:**
			BMI ≤ 30: Enoxaparin 40 mg subcutaneous Qday **BMI > 30:** Enoxaparin 40mg subcutaneous Q12hr	Enoxaparin 30 mg subcutaneous Qday **or** UFH 5,000 units subcutaneous Q8hrs
LEVEL 2:				
NO VTE	**and any of the following:**	• D-dimer ≥ 6.0 mcg/ml FEU • D-dimer increased by ≥ 2.0 mcg/ml FEU despite 48hr of prophylactic LMWH or UFH • Inability to dialyze due to clotting in line, filter, or machine	**CrCl≥ 30 ml/min**	**CrCl<30ml/min:**
			Enoxaparin 0.5 mg/kg subcutaneous Q12hr (pharmacy may to round to nearest vial)	Low Dose IV Unfractionated Heparin Protocol (use approved order set)
LEVEL 3:				
KNOWN or SUSPECTED VTE	**or**	Inability to dialyze due to clotting in line, filter, or machine despite Level 2 anticoagulation	**CrCl≥ 30 ml/min**	**CrCl<30ml/min:**
			Enoxaparin 1 mg/kg subcutaneous Q12hr (pharmacy may round to nearest vial)	DVT/PE IV Unfractionated Heparin Protocol -Use approved order set -Consider eliminating bolus if recent Anti-Xa at/near goal or LMWH recently dosed
Consider if: Patient requires FiO2 > 50% or O2 flow ≥ 6L/min (mask or NC) for >4 hrs while on Level 1 or 2 anticoagulation				
LEVEL 4:				
Patient develops any of the following while therapeutic on treatment dose of unfractionated heparin or enoxaparin: (1) VTE (2) Suspected HITT (3) D-dimer persistently >20 mcg/ml FEU (4) Inability to dialyze due to clotting in line, filter, or machine despite Level 3 anticoagulation			Check: -Cardiolipin Ab Panel -HITT screen (if indicated) -Antithrombin III activity -Beta-2 Glycoprotein Ab Panel	
			Options: -Consider using Anti-Xa for LMWH dosing -If patient has breakthrough clotting while on therapeutic LMWH (and HIT is not suspected), consider increasing LMWH dose by 25% -If HIT is suspected, consider switching to argatroban or fondaparinux (fondaparinux requires less nurse/phlebotomy contact with patient) -If emboli are suspected, consider thrombolysis	

[1]Guideline may be updated as new data become available regarding anticoagulation for COVID-infected patients.
[2]For patients with platelets <50,000/mL we recommend workup other etiologies and consulting hematology.

DHS Expected Practices: Titrating Oxygen, DME Oxygen

Found under “Rotator Resources” and “COVID-19” on our Chiefs’ Blog.

Reviews how to titrate oxygen in patient and also how to discharge a patient on home oxygen

PROCESS TO SECURE HOME OXYGEN/PULSE OXIMETER FOR INPATIENTS- COVID+ WEEKDAYS/WEEKEND/AFTERHOUR

1. Provider writes order: DME Home Oxygen
2. Provider writes order: DME Home Pulse Oximeter
3. Provider calls Calox Liaison Liset Herrera for inpatient discharges (8-5pm) 323-217-7696
4. Provider calls Calox, Inc. afterhours/weekends 323-255-5175 and asks to speak to the "on-call" manager who will process Home Oxygen
5. To obtain a pulse oximeter: MD places order under DME pulse oximeter, calls IPT Warehouse (C1L100) 9-2381
6. RN/MD/Unit Clerk fills out HS1 or HS2 form and takes it down to IPT warehouse to pick up monitor for Discharge

** Note: If Calox is unable to provide home oxygen or any barriers to time sensitive inpatient discharges, see the ED discharge process below and follow the same process to secure home oxygen and pulse oximeter. ↓. MD will pick up O2/Pulse Ox from ED

More (But Less Urgent) Nursing Calls

“Doctor, patient is vomiting…”

- Consider underlying condition
- What are the other underlying complaints?
- Large volume emesis may over time cause complications (ie, dehydration or electrolyte imbalances)
- Can try medications: ondansetron, metoclopramide, prochlorperazine, sublingual Ativan, scopalamine patch
  - Watch for contraindications, relative or absolute

“Doctor, patient is constipated…”

- Consider: Medication-induced? SBO?
- Evaluate the patient; physical exam
- Multiple drugs available: stool softeners, stimulants, enemas, osmotic agents, prokinetic agents
- All patients prescribed opioid medications should also have a bowel regimen
- Do not forget underlying conditions (ex: no Mg/Phos containing products in renal patients)
- Ask your patients daily about bowel and bladder habits; each pt. should be having a bowel movement every 1-3 days while hospitalized

“Doctor, patient has diarrhea”

- Ask for the character of the diarrhea (watery, loose, soft)
- Consider drug-induced causes
- Is there blood in diarrhea?
- Watch out for complications (ie, electrolyte imbalances, dehydration)
- Do not give antimotility agents until infection is ruled out given higher risk of C. diff in hospitalized patients
- Do not order C diff toxin on everybody!
- Flexiseals are not benign and cannot be placed on the floor!
- Consider stool studies though in most cases they will not be necessary

“Doctor, patient is combative…”

- Is the patient endangering self and/or staff? Call a CODE GOLD and/or have nursing call Sheriff
- Haldol 5 mg IM, Ativan 2 mg IM, Benadryl 50 mg IM (aka the 5250 cocktail)
- Can also give olanzapine 10 mg IM (DO NOT GIVE WITH IV ATIVAN)
- Watch out for side effects such as dystonia and QTc prolongation!
- Patients with previous exposure to these agents may have tolerance but take care in repeat dosing
- Any time you restrain a patient, you should also give a medication

“Doctor, patient just fell…”

- ASK FOR FULL SET OF VITALS
- Did the patient hit their head? Was there any loss of consciousness?
- Interview nurses, sitter, family/visitors
- Consider CT head w/o contrast
- Consider neuro checks (q4h on floor, q2h in PCU, q1h in ICU)
- Consider bedside commode, physical therapy/occupational therapy evaluation, sitter
- Is this a patient who will need SNF? Engage SW early

“Doctor, patient is bleeding….”

- Full set of vitals!
- Assess the patient
  - Manual compression, pressure dressings
- Labs: type and screen, CBC (plts, H/H), PT/INR/PTT
- DIC? Add fibrinogen, d-dimer, peripheral smear
- If transfusing, make sure they are consented and placed in paper chart
  - No “double-doc” anymore. If urgent, document need for emergency consent in the chart
- GI, IR, surgery consults if required

“Doctor, patient wants to sign out AMA…”

- LAC+USC is not a jail, patients can leave AMA. BUT…
- Patient must demonstrate capacity
- Must be informed about risks, benefits, alternatives
  - Try to convince pt. to stay
- MD is not obligated to give medications though it may be appropriate for some patients
- Try to arrange for follow-up appointment
- DOCUMENT conversation, sign AMA forms
- Try to get contact information, document in chart
- Discharge the patient
- Jail patients can leave AMA back to jail

“Doctor, patient has died….”

- Notify senior resident, attending
- If family present, introduce yourself and what you will be doing.
  - Empathy!
  - Give them the option of waiting outside if they would prefer.
- Perform death exam
- Notify family either in person or by telephone
- Organ donation? Autopsy?
- Social work? Religious services/chaplain?
- Death packet; will need a signature by MD with license
- Death note in chart

Unsure about what do?

YOUR SISTER TEAM'S RESIDENT

YOUR RESIDENT

ANY MEDICINE TEAM RESIDENT

MEDICINE CONSULT

ANY MEDICINE RESIDENT

YOUR CHIEFS

YOUR ATTENDING OR ATTENDING OF THE DAY

QUESTIONS?