How I Triage Overnight

Residents as Teachers: Transition to Senior (Overnight Triage)
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With thanks to the great Wayne Hung!

What are your roles as CTU Sr overnight?

So we triage... what else?

What are your roles as CTU Sr overnight?

- ❏ Main point of contact between ED and CTU
- ❏ Assumes care of all patients admitted in ED
- ❏ Triages appropriately for dispo and assignment
- ❏ Initial management and resuscitation
- ❏ Reviews cases with learners
- ❏ Supervises necessary overnight procedures
- ❏ Handover to incoming day team
- ❏ Teach whenever possible!

First... let's get prepared!

A goodnight starts with good preparation!!!

How would you get ready for the night?

First... let's get prepared!

- ❑ Print out tracker (if not already done)
  - ❑ Found on computers and online @ bit.ly/morgancallresources
- ❑ Get contact info of team members on call
- ❑ Check who is on for XC and CA
  - ❑ Your best friends overnight!
- ❑ Meet daytime Senior for handover at start of shift
- ❑ Touch base with on-call Staff and get contact info
  - ❑ Make note of when staff is returning and keep staff updated on # of consults to review, etc.
- ❑ Quick review of CTU site policies and resources
  - ❑ Exception to transfer policy - site dependent!
  - ❑ Dispo options: DTU, Family practice, Geri/10C, ED Fast Track, IMOC etc.
  - ❑ Where are procedure kits located?

Your pager rings - what to do???

Time to communicate with the Emerg physician

What are important things to ask and discuss?

Can you refuse or redirect consults over the phone?

Your pager rings - what to do???

- ❏ Set yourself up with a computer and phone
- ❏ Standard question set:
  - ❏ Demographics: full name, MRN, location
  - ❏ Stability: VS, LOC, need for high flow/BIPAP, need for pressors?
  - ❏ What has been done?
    - ❏ E.g. Workup - Imaging? Septic workup? Other consultant called?
    - ❏ E.g. Management - ABx? Fluids vs. diuresis? Insulin infusion?
  - ❏ What is the patient getting now?
  - ❏ If unclear, what does ED physician think is happening?
- ❏ If needed, ask for EDP to put in imaging orders
  - ❏ Often gets done faster
- ❏ If procedure may be needed (taps, LP) up to your discretion whether to ask ED physician upfront

PROTIP

Unless 100% certain, triage first then re-discuss appropriate disposition with Emerg physician!

AKA - never wrong to err on the side of caution

Time to go actually see the patient...

Which tasks need to be done?

Which patients do you see first?

In what order do you do your tasks?

The components of triaging

- ❏ Prioritizing patients based on acuity and complexity
- ❏ Collecting bedside information
- ❏ Collection background information
- ❏ Inputting initial orders for workup and management
- ❏ Deciding patient disposition
- ❏ Assigning and guiding housestaff
- ❏ Reviewing the case
- ❏ Following up and reassessing often!

The components of triaging

But how do I remember all this...???

New mnemonic... ABC-DART!

See handout!

New mnemonic... ABC-DART!

A = Acuity
B = Bedside and Backgroud
C = Covering Orders

D = Disposition
A = Assignment
R = Review (and Teach)
T = Tasks and follow-up

A = Acuity

How quickly do I have to see this patient?

A = Acuity ~ 5-10 mins

How urgently do I have to triage this patient, especially if bolus'd?

- ❏ If patient sounds acutely ill, eyeball first before doing background work!
- ❏ Urgency via ED physician:
  - ABCs OK? (e.g. LOC, BP, HR, O2 requirements)
- ❏ Urgency via bloodwork:
  - CBC (Hgb, Plt, neutropenia)
  - Metabolics (Na, K, Ca, acidosis, lactate, gluc)
  - Liver panel (thousands club, coags)
- ❏ Urgency via imaging:
  - Brain/chest/abdo (anything life-threatening)

B = Bedside and Background

Who is this patient and how do they look?

B = Bedside and Background ~ 20-30 mins

Who is this patient and how do they look?

- Chart review: VS trend, EHS notes, interventions done
  - Talk to RN about concerns
- Bedside:
  - Focused Hx and PEx, fill out Caution sheet
  - Bring US for quick volume/organ scan
  - Do all relevant exams for verification later
  - Pre-emptive code discussion if issue or MSI
- Background check:
  - Prev notes, imaging, cardiac tests, labs, micros
  - Med Rec to get snapshot of health
  - If time allows, access Careconnect and print

PROTIP

The sicker the patient is, the more you need to know

If very stable, can allow housestaff to delve into details

C = Covering orders

What further testing and treatments are needed right now?

C = Covering orders ~ 5-10 mins

What further testing and treatments are needed right now?

- Workup: Bloodwork? Imaging? Urine? Micro? Cardiac?

- Management: ABCs: LOC: Use DIMS approach
  Breathing: Nebs? RT? Diuresis? ABx?
  Circulation: More or less volume? BP and HR control?
  Monitoring: Telemetry? Special nursing assignment?

- Communicate to RN if critical orders needed

PROTIP

If stuck, think about orders that the patient will survive on overnight

D = Disposition

Is this an appropriate CTU admission right now?

D = Disposition ~ 5 mins

Is this an appropriate CTU admission right now?

- ❏ Patient is appropriate:
  - Use triage PPO to admit with covering orders
- ❏ Patient too unstable currently:
  - May need a few hours of therapy and reassess → Exception to transfer
  - Way too sick and needs ABCs managed first → Call ICU / discuss with ED physician
- ❏ Patient not acutely ill:
  - Submit covering orders for workup and mgmt
  - Tell RN that decision to admit is TBD

A = Assignment

How complex is this patient and who should take care of them?

A = Assignment ~ 5-10 mins

How complex is this patient and who should take care of them? (should I be involved?)

- ❏ Single/few active issues → MSI3 (Good to know where they are in rotation too!)
- ❏ Complex + sick + intertwined issues → IM Jr
- ❏ Ideally, write a triage note to help capture pt status and issues
  - ❏ Be cognizant that you are not doing the full consult!
- ❏ Give learner time limit and high yield areas of focus
  - ❏ Make sure to ask about X, examine for Y, think about Z
- ❏ If available, direct learner to resource for guidance
  - ❏ A good one is Approach to Internal by David Hui

R = Review (and teach)

How does the housestaff's story compare to mine?

R = Review (and teach) ~ 15-20 mins

How does the housestaff's story compare to mine?

- Improve presentation flow: History easy to follow and complete?
  PEx relevant pos and neg?
  Can they interpret the labs/imaging?
- How to organize any issue: Prov Dx / DDx / Investigations / Management
- Always a good opportunity for U/S assessment and teaching if applicable
- **Review all admission orders prior to submission!**

R = Review (and teach) ~ 15-20 mins

Competency by Design:

- Prepare your R1's for the AM:
  - The more confident they feel in their management plan, the more likely they'll be to ask for EPAs
  - Morning reviews are great opportunities for "Assessing, diagnosing, management" EPAs
- Procedures:
  - LPs, Thoras, Paras
  - Per your comfort level! If not urgent or critical to disposition, may be better done in the AM
- Code Discussions, Internal Med Consulting, Family Discussions, all potential EPAs overnight.
- Supervising junior learners EPA

T = Tasks and follow-up

What do I need to keep an eye on?

T = Tasks and follow-up ~ All night long!

What do I need to keep an eye on?

- ❏ Keep big board updated with information
  - ❏ T (triaged?) A (admitted? R (reviewed?) S (staff review?)
  - ❏ Remember to keep track of which housestaff and which team
- ❏ Make checklists of patient issues to follow up on
- ❏ Explicitly assign tasks to learners
  - ❏ Give them the sense of responsibility and ownership of care
  - ❏ But ultimately you should be following all important tasks overnight
- ❏ Keep track of AM patient issues to handover
  - ❏ E.g. patient needs an urgent CT-head, we need to call Nephro for dialysis in the AM, etc.

PROTIP

Lay eyes on your sick patients often!

In summary, how I triage overnight

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Step 1) Be prepared!

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Step 2) Take the consult and ensure open communication with ED

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Step 1) Be prepared!

Step 2) Take the consult and ensure open communication with ED

Step 3) Triaging

→ Remember ABC-DART

A = Acuity

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R = Review

T = Tasks to follow-up

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Protip #4: The sicker the patient, the more you need to know, and vice versa

Words of wisdom

Protip #1: Unless 100%, triage first and re-discuss with ED later

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Protip #3: Reassess sick patients often!

Protip #4: The sicker the patient, the more you need to know, and vice versa

Protip #5: Give your housestaff explicit responsibilities, but ultimately it's on you!

OK, what if I’m overwhelmed?

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- ❑ Prioritize - non-urgent cases can keep waiting through the night
- ❑ Get someone started on a non-sick consult/seeing the patient while you triage
- ❑ Perform the bedside assessment with your junior concurrently
- ❑ Ask staff to help triage or review patients
- ❑ Ask your best friends on XC and CA if they're available to help
- ❑ As a last resort, do consults yourself

MOST IMPORTANT PROTIP

If you're worried or need help, call your attending!!!

COVID Corner

- Minimize exposure whenever possible
  - If seen by ED doc and relatively straight forward, does the patient need another exam tonight?
  - Calling patients on their phones from outside the room
  - Discussion with Nursing re limiting assessments, bloodwork, whenever possible
- Monitor O2 requirements overnight
  - 4 L: Call CCOT
  - 6 L: to ICU (although worth giving them a heads up well before hand)
- If suspicion moderate to high, no rush to D/C precautions and consider additional swabs / sputum PCR.

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Questions or comments?