Night Float Survival Guide

Night Call Survival Guide.doc

HyperKalemia:

1. DC all K^+ and all drugs increasing K^+
2. STAT repeat K^+
3. 1 amp D50 + 10units IV insulin
4. Albuterol 10mg nebulized over 20min (4 vials)
5. 1 amp HCO3
6. +/- 1 amp CaCl or Ca-Cluconate
7. Kayexelate (If gut working) 15-60 grams PO or 30-50 grams retention enema, repeat q6hrs
8. Hemodialysis if renal patient

HypoKalemia:

- Each 20-30meq K^+ will raise K^+ by 0.1meq/L
- IV rate not to exceed 10meq per hour
- Try to correct K^+ to the low end of scale; (shoot for 3.7)
- Do not give more than 60meq before rechecking

HypoMagnesemia:

- 1-2 grams Magnesium Sulfate IVBP over 1-2 hrs

HypoCalcemia:

- 1-2 grams CaCl or CaGluconate IVBP over 1-2 hrs

HypoPhosphatemia:

- Neutra-PHos-K: 1 packet PO
- Na-/K-Phos IV over 6 hrs (4.4mEq Na or K in 3mmol)

PO4: 1.6-2.1 mg/dL give 0.15 mmol/kg

1.2-1.5 0.3

0.8-1.1 0.45

<0.8 0.6

Hiccups:

- Chlorpromazine 25-50 mg PO TID-QID (if no contraindication; can give IM or IV if refractory to oral treatment)
- Baclofen 5-25mg PO TID
- Metoclopromide 10mg PO TID (if no contraindication)
- Gabapentin 100mg BID

Antiemetic:

- Ondansetron 4mg IV/PO q6hrs prn - check last EKG for QTc
- Metoclopramide 10mg PO qac /TID (5mg in elderly) prn (may give as a single dose IV)
- Promethazine 12.5-25mg PO/IV/IM q6 hrs prn

Anxiety:

- Lorazepam 0.5-2mg IV/IM/PO q4-6 hrs prn
- Diazepam 2-10mg PO BID/QID prn
- Alprazolam 0.25-1mg PO BID/QID prn

Agitation

- Haloperidol 1-5mg PO/IM/IV q4-8 hrs prn
- Lorazepam 1-2mg PO/IV q2-6 hrs prn

Chest Pain:

1. VS, O_2 sat, O_2 if needed
2. STAT EKG, STAT PCXR
3. Lytes, Cardiac Enxymes +/- ABG
4. Chew 4 baby ASA (325mg)
5. NTG 0.4mg SL q5min x3
    a. NTG gtt if pain doesn't resolve, titrate gtt for pain
6. MI:
    a. Heparin wt-based protocol
    b. P2y12 inhibitor (e.g. Clopidogrel - check with cardiology before administering)
    c. High intensity statins (Atorvastatin 40-80mg daily, Rosuvastatin 20-40mg daily)
    d. Metoprolol 12.5-50mg q 6-12 hours (PO preferred within first 24 hours; Alt: metoprolol 5mg IV, may repeat q5min x 3 doses
        i. Hold for HR<50 or SBP<100
        ii. Caution with new onset HF or reduced EF)
    e. Carverdilol 3.125-6.25mg PO q6hrs
        i. Hold for HR<50 or SBP<100
        ii. Caution with new onset HF or reduced EF)
    f. Morphine 1-2mg q2-4 hrs prn pain

SOB:

1. O_2 sat, give O_2
2. STAT ABG and PCXR
3. Meds:
    a. Ipratropium/Albuterol (DuoNeb) 2.5mg-0.5mg/3ml INH q4-6hr
    b. Levalbuterol 0.63-1.25mg aerosol if pt. tachy
    c. Lasix for CHF (40-80mg IV)
4. BiPAP 15/5
5. Intubation if needed - call ICU

Low UOP:

Hypotension:

1. Fluids!!!
    a. If pt is on a vent give 1 liter @ a time
    b. If pt is CHF give 500cc @ a time
2. Pressors: Have nursing titrate for Mean of SBP
    a. Norepinephrine: 1-50mcg /min
    b. Vasopressin: 0.01-0.04units /min
    c. Phenylephrine 10-200mcg /min
    d. Epinephrine 2-10mcg/min
    e. Dopamine 1-20mcg/kg/min

A-fib w/ RVR:

- Diltiazem gtt, titrate to keep HR < 110
- Oral conversion: [(gtt rate * 3) + 3] * 10 = oral dose

SVT:

1. Adenosine 6mg IVP, may repeat w/ 12mg
    a. Max of 3 doses
2. Metoprolol IV 5mg q5min x 3
    a. Hold for SBP < 100
3. Diltiazem: Bolus 0.25mg/kg IBW x2, then gtt
4. Esmolol: Bolus 500mcg/kg over 1 min
    a. then 50mcg/kg for 4 min, if no response titrate drip up by 50mcg/kg/min to max of 200mcg/kg/min

Hyperglycemia: Insulin SS:

0-70: 1 amp D50 (alt: OJ/Skim Milk), Recheck

71-120: 0 units 121-150: 1 unit

151-200: 2 units 201-250: 4 units

251-300: 6 units 301-350: 8 units

351-400: 10 units 400+: Call HO

-Recheck BS in ~4 hours!!! (Peak effect of Insulin-Regular)

Fever:

- Acetaminophen 650-1000mg PO or 1 gram PR q6hrs
- Fever > 102°F: (38.9°C)
    - Blood Cx x2, U/A w/ C&S, Sputum Cx + Gram stain
- CXR
- Cooling blanket if all else fails

HTN:

1. Metoprolol 5mg (2.5-10mg) IV q6hrs

- Prochlorperazine 5-10mg PO/IV/IM q6-8 hrs prn

Diarrhea:

- Loperamide 4mg PO, then 2mg PO after each loose stool thereafter, - Max 16mg/day (for non-bloody diarrhea)

Laxatives:

- Docusate sodium 100mg PO BID /QID prn
- MOM 5-15 ml PO q6hrs prn
- Polyethylene Glycol 3350 (Miralax) 17g daily
- Tap Water Enema
- Soap Suds Enema
- Mag Citrate ½ to 1 bottle (Strong)
- Glycerine Suppository
- Bisacodyl Suppository 5-10mg PO /PR QD (Strong)
- Metoclopramide 10mg PO qac /TID (5mg in elderly)

Indigestion:

- Maalox Plus 10-20cc PO q4-6 hrs prn
- Tums Extra Strength 1-2 tabs PO q4 hrs prn

Sleepers:

- Melatonin 3mg PO QHS
- Zolpidem 5-10mg PO qhs prn (5mg in females)
- Temazepam 15-30mg PO qhs prn (7.5mg in elderly or debilitated patients)
- Diphenhydramine 25-50mg PO qhs prn (Don't use in BPH, Caution in elderly)

EtOH:

- Thiamine 100mg PO/IV + Folate 1mg PO/IV
- MVI PO/IV, IVF: D5 after thiamine given
- Lorazepam or Phenobarbital (Never both)

DKA

- Fluids:
  - Give 2 liters of NS over the first 2 hours
  - Then give ½NS at 200250ml /hr
  - when BS ~200250 change IVF to D5½NS
- Insulin gtt:
  - Intital bolus 0.1 units/kg IV
  - IV rate 0.1 units/kg IV
- If pt going to the floor, use the following parameters:
  - Decrease rate by 1 unit if BS decreases by 100
  - Decrease rate by 2 units if BS decreases by 200
  - Increase rate by 1 unit if BS decreases by 100
  - Increase rate by 2 units if BS decreases by 200
- Fingerstick BG check q1hr

1. Flush foley or do straight cath
2. Bladder scan
3. Bolus IVF (if pt has good heart) 500-1000cc NS
4. Furosemide 20-80mg IV - call senior first

ET Tube:

- Placement should be 3-5cm above the carina. Always get CXR after intubation

NG Tube:

- CXR for placement. Make sure the NG tube is below the diaphragm. Make sure the feeding tube is not in bronchus!

Pronouncing Death:

- (Have Pastoral Care present for pt. & fam.)

- No spontaneous breathing, no HR, no pulse via Doppler, no response to painful stimuli, pupils fixed and dilated. Record findings in chart as well as time of death. Notify attending and family. Have the family leave the room while pronouncing.

Code Status:

- Full Code:
  - Anything and everything. Know your ACLS
- DNR
  - Continue all treatment, but in the event of cardiac arrest do not perform chest compressions or cardiac defibrillation
- DNR-DNI (Not Intubation)
  - Same as DNR, but do not intubate
- DNR-CC
  - Comfort care only
- Always document any conversation you have with family or the patient regarding code status. If you don't document it other physicians may not know what you have done.

Oxygen:

- For each liter you add it raises FiO2 by 3%
- Nasal Canula:
  - Max 6 Liters/min = Max FiO2 of 40%
- Non-Rebreather Mask
  - Max 10 Liters/min = Max FiO2 of 60%
- Non-Rebreather Mask with Reservoir
  - Max 15 Liters/min = Max FiO2 of 80%

BiPAP

- Non-invasive mechanical ventilation
- Initial settings of 15/5 usually works well

2. Enalapril 1.25mg (0.625-2.5mg) IV q6hrs
3. Hydralazine 10mg (10-20mg) IV q6hrs
4. Clonidine 0.1mg (0.1-0.3) PO q1hr (Max 0.6mg)
5. Labetalol 20mg IV, then 40-80mg q10min (Max 300mg/day)

6. Drips:
   a. Labetalol: start @ 1-2mg /min, may titrate up to 10mg /min
   b. Esmolol: Loading dose 500mcg/kg/min in 1 min, then 50-200mcg/kg/min
   c. Nicardipine: start @ 5mg/hr (Max 15mg/hr)
   d. Nitroprusside: start @ 0.3-0.5mcg/kg/min (Max 10mcg /kg/min {Cyanide poisoning})

Central Line Placement:

- Tip of central line should be just outside the right atrium. It is ok if it is just inside the tricuspid valve, but if it is in the right ventricle if must be pulled back.
- If placing a Left IJ - Make sure the central line passes the midline of the chest, if it does not, it may be in the aorta
- If you have even a small amount of concern, make sure you have the nurse connect the line to a transducer to see if it has a waveform, look for arterial pressures

Leaving Against Medical Advise (AMA):

- Assess patient to ensure he/she has the capacity to make decision
- Talk to patient first, attempt to answer their questions, and discuss possible consequences of leaving AMA
- Notify your senior resident
- Document your conversation with patient
- Patient on 5150/1799 hold are not allowed to leave AMA

- KCL Replacement:
    - Pts. Will require ~ 37meq KCL/kg during their treatment
- DC Insulin gtt when serum ketones are clear

Blood Transfusions:

- Always check Iron studies before blood transfusions!

Iron Studies:

- TIBC, Ferritin, Serum Iron, % Iron Saturation

Cocaine Induced HTN:

- Do not use Beta Blockers!!!
- Clonidine 0.1mg PO q1hr (Max 0.6mg /day)
- Hydralazine 10-20mg IV q4-6hrs
- Enalapril 1.25-2.5mg IV q6hrs

Seizures:

- If pt. not actively having seizures hold off on meds
    - Cannot get good results on EEG if pt is on meds
- If pt. is actively having seizures:
- Lorazepam
    - 2-4mg q5min while patient is having a seizure
- Midazolam
    - 0.2mg/kg IM (if no IV access); max 10mg/dose

- Phenytoin:
    - Loading dose: 15-25mg/kg (~1 to 1.5g)
    - Maintenance dose: 300mg /day TID
    - Check levels for toxicity
    - Look for ataxia and nystagmus

Status Epilepticus:

- Phenobarbital: loading dose of 10-20mg/kg IV by slow or intermittent injection
- Valproate: loading dose 20-40mg/kg over 15 minutes (max 3000mg)
- Fosphenytoin: 18-20 PE/kg (max 1500mg PE)
- Levetiracetam: 60mg/kg IV (max 4500mg)

PE:

- High intensity weight based heparin

Cough:

- Guaifenesin 100mg/5ml, 5-10ml every 4 hours prn (use Sugar-free formuation for patients with DM)
- Guaifenesin + Dextromethorphan 100mg-10mg/5ml, 10-20ml evrey 4 hours prn
- Benzonatate 100-200mg PO TID prn

Acute Pain Management:

- Non-opioids (mild-moderate pain)
    - Acetaminophen 325-650mg every 4-6 hrs prn (max 4g /day or 2g/day if hepatic insufficiency)
    - NSAIDS (Ibuprofen 200-800 TID to QID prn (max 3200mg /day); Naproxen 250-500 BID (caution in renal impairment)
    - Topicals: Diclofenac gel, Lidocaine ointment/cream, Capsaicin cream
- Opioids (moderate-severe pain)
    - Hydrocodone/APAP 5mg /325mg 1-2 tablets every 4-6 hrs prn (max APAP 4g /day)
    - Oxycodone 5-10mg every 4 hrs prn
    - Morphine IR 5-15mg every 4 hours prn
    - Tramadol 50 every 4-6 hrs prn (avoid if h/o seizures)

Acute GI Bleed:

- VS (HD stable vs unstable), O2 sat, O2 if needed
- IV access with 2 large bore IVs; if HD unstable, start IV fluid resuscitation, blood transfusion (goal Hgb >7 or >8 if h/o CAD)
- Assess for airway protection and need for ICU
- STAT CBC, PTT, PT/INR, type and cross, LFTs, BUN, Scr
- Discontinue antiplatelets /anticoagulants; consider anticoagulant reversal agents (e.g. PCC, FFPs) if indicated
- If Upper GI bleed suspected
    - Non-variceal bleed: start Pantoprazole 80mg IV bolus, followed by gtt at 8mg /hr
    - Variceal bleed: Pantoprazole as Above + Octreotide 50mcg IV bolus x 1, followed by gtt at 50mcg /hr x 2-5 days
- If patient with with cirrhosis/ascites and GI bleed, start antibiotic prophylaxis and continue for duration of 7 days
    - Ceftriaxone 1g daily
    - Norfloxacin 400mg PO BID

- Consult GI if hemodynamically significant GI bleed