**Bed Czar Top 10 Most Frequently Asked Questions**

Literally pulled from emails to the Chief Residents. Review in detail with your orienting attending.

**1. Who is my supervising attending? When should I call them?**

You should be able to contact the correct attending via role-based communication at all times p57738, x7738. The admitting hospitalist may be an attending with only the role of admissions or they may have other responsibilities (Bear Direct, PHAST). Hospitalist amion: amion.com, log in: cnmcphm

Be sure to touch base with your attending at least at the following times:

* At the start and end of each shift
* Text page as soon as you accept each admission
* Call to talk about your assessment and plan soon after you see each patient
* Immediately if you disagree with the Emergency Department regarding the appropriateness of an admission. These patients must be evaluated by an attending within 15 minutes of the ED call.
* **Whenever you’re concerned, we’re concerned (see hospitalist supervision policy).**

*Please do not batch admissions.*

**2. What do I do when I get a call about an admission? How do I know that I’ve completed everything each patient needs without admissions or errors?**

Use the same process for each patient. Use the admission tracker every time to be sure that you don’t miss any steps. No admission is complete until all checklist items are completed or explicitly delegated to another provider.

|  |  |
| --- | --- |
| * Admit criteria met *(see criteria on admission tracker)*
* Assign to team *(MUST assign prior to hanging up the phone)*
* Add to census immediately
* FYI text attending *(do not skip this step, do not batch admissions)*
* See patient
 | * Write or review orders in detail with intern
* Staff (discuss in detail)with the attending
* Complete or edit the H&P
* Complete IPASS Cerner Document
* Sign-out to 1**°** team resident
* Ensure shared mental model w/ RN
* Call PCP (or sign out this call out to the 1**°** team)
 |

Review the tracker with your attending at the start of your first shift to be sure that you understand all of the steps.

**3. When do I assign a team?**

Teams should be assigned **prior to hanging up** with the referring provider. Failure to do so leads to delays in patient care. For this reason it’s important that you know the team censuses from the very beginning of your shift. If you must change a team after assignment, you can notify the ED provider and admissions then change the ED Bed Request order.

When in doubt whether a patient is appropriate for PHAST, **assign to PHAST**, **then call** the PHAST attending to confirm. The worst that can happen is that you have to change the ED bed request order and call admissions to change the team.

**4. How do I triage patients?**

The Admissions flowchart in **Appendix A** is helpful to assist with patient triage to the Hospitalist teams. Any questions should be addressed to the Admissions attending during orientation.

It is essential to consider the following when triaging patients:

* Current clinical status (i.e. stable, unstable, respiratory distress, compensated shock, etc)
* Current vital signs (ask during the call requesting admission)
* Differential diagnosis (generate this while you’re on the phone)

**5. What if I disagree with the appropriateness of an admission or have safety concerns?**

Please review this section of Appendix A with your attending. It is your responsibility to ensure safe and efficient throughput from the ED. If there are any concerns regarding the appropriateness of the admission then do the following:

* During the initial ED call: Identify specific features of the hx & exam that you are concerned about and tell them to the ED provider. Ask for clarification. If you are talking to a medical student or resident, ask to speak with their fellow/ attending. If you still disagree, then obtain their name and call back number.
* Within 5 minutes: Discuss with the hospitalist admitting attending @ ascom 7738/ p57738.
	+ If concerns are resolved 🡪 call the ED to accept the patient ***within 15 min of initial call***
	+ If concerns persist🡪 go to the ED **with the admitting attending** immediately and evaluate the patient. The hospitalist attending must discuss with the ED attending ***within 30 minutes of the initial call.*** If the ED and hospitalist attendings disagree then the hospitalist attending will call the ED Charge MD.
1. **Are there specific admission criteria for the any of the Hospitalist teams?**

*Exclusion criteria for Children’s National’s hospitalist service* (also noted on admission tracker):

* 21 years old or older
* Pregnant (all post-menstrual female patients should have a urine pregnancy test)
* Requires hourly monitoring or support not provided on an acute care unit
* Admission for single organ system problem that is appropriate for a subspecialty team
* Kaiser insurance

*PHAST criteria:*

Given the Q12 hour sign out and variation in providers per week on PHAST, the goal is to avoid admitting patients who require complicated hand-offs (ie a patient without a known diagnosis or where the diagnosis is uncertain) and where daily changes in plan are anticipated. There is no limitation based on anticipated length of stay or acuity of care.

Criteria include:

* Narrow differential diagnosis
* Generally healthy patient
* No complicated PMH
* No family/ patient situation requiring continuity of care (NAT, neglect concerns)
* Less than 3 consulting services involved (exception orbital cellulitis where ID, ENT, Ophthalmology are usually involved)

Examples of included diagnoses: bronchiolitis, asthma, cellulitis, osteomyelitis, complete or incomplete Kawasaki Disease, UTI, febrile neonate, neonatal jaundice, etc.

Examples of excluded diagnoses: failure to thrive, BRUE, most diagnoses in children with medical complexity even if reason for admission is “simple” like post MRI observation, most diagnoses in children with concern for NAT or neglect, any patient without a clear/definitive diagnosis.

*Examples of PICU referral criteria:*

* Requiring FiO2 >50%
* Asthma score >7
* Continuous albuterol for patients <36 months old
* Unstable airway, VS, ABG
* Active seizures
1. **Which patients should I see in the Emergency Department?**

See Appendix A.

Please be considerate of ED throughput. Do not hold patients up in the ED unless it is absolutely necessary for safety. Any additional studies, labs, history, or exam that can be done on the floor should be deferred if safe.

See patients in the ED if:

* an early assessment is important (i.e. respiratory distress)
* you have concerns about appropriateness for admission (see #8)
* after accepting the patient and assigning the team if there are no patients waiting on the floor, particularly if it is near change of shift.
1. **What feedback do I get during my Bed Czar experience?**
* During each call to the attending, much of your discussion is feedback on your assessment skills.
* Weekly written feedback from 3:30p-11:30 & other hospitalists you work with will be completed on paper and scanned into MedHub.
* Peer evaluation – MedHub
* Since you may work with a several attendings each week, please be proactive and ask for verbal feedback each shift.
1. **What if all teams are capped and AT 4 must be activated?**

Huddle with the hospitalist attending to review and implement the hospitalist team high census plan. See the procedure on [ResidentBook 🡪 Admin 🡪 Policies 🡪 Residency Program Policies 🡪 AT4 Activation Plan](http://www.childrensmedicaleducation.org/residents/course/view.php?id=30). You will continue to perform admissions to AT 4 along with the admitting hospitalist. Be sure to work with the hospitalist and other seniors to assess resources and recruit help when possible.

1. **What if there aren’t enough beds for the patients due to high census?**

Escalate this concern to the admitting hospitalist and bed control / A.D. immediately. It is beyond the scope of your responsibilities to make these decisions and you should not be asked to do so.

**Bonus Question: When do I stop admitting patients?**

\*Accept patients until 6am: No new H&Ps to be started after 5:30am; Ensure all accepted pts are appropriate for floor and have orders; if patient is directly admitted to the floor, please help with admit orders.