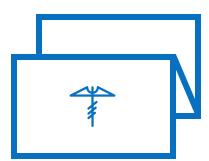
Inpatient Pocket Cards



tinyurl.com/InptPCS

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Satya Patel, MD, Kelley Chuang, MD, Jennifer Fulcher, MD, PhD, Simon Wu, MD, Tyler Larsen, MD, Michael Spiker, MD, Michael F. Ayoub, MD, Sean McCarthy, MD, Estelle Everett, MD, Pamela Tsing, MD, Ashley Saito, MD, Anand Jagannath, MD, Priyanka Moolchandani, MD, George Tran, Jaime Betancourt, MD Antonio Pessegueiro, MD

Made with assistance from ChatGPT and OpenEvidence

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Pre-Rounding Guide					
Overnight Events	Night float signout, nursing notes				
Interdisciplinary Notes	Review original note and any addendum				
Vital Signs	Trends and ranges (min and max) values				
I/O and Weights	Input: Oral, IV, via feeding tube Output: Urine, stool, drains, ostomy, hemodialysis Weight trends				
Labs	Include trends Review pending/send-out labs Consider which ones are truly needed on daily basis				
Radiology	Review images yourself Note if interpretation is preliminary or final				
Microbiology	Bacterial culture not considered "negative" until at least 48 hours (does not finalize until day 5)				
Pathology	Review initial stains and pending stains				
	IV fluids and drips				
	Missed doses of medications (and reason for missed doses)				
	Review medications that have expired/"fallen off"				
Medication	Review medications that need to be discontinued				
Administration	Overnight medications that were written by night float				
Record (MAR)	Pain medications				
,	Insulin requirements (and glucose ranges)				
	Antibiotics received and start/end dates				
	Review if held/modified home meds can be restarted/returned back to home dose				
Cardiac Monitoring/Pulse Oximetry	Review telemetry Consider if cardiac monitoring and/or pulse oximetry needs to be continued				
Tubes, Lines, Drains	Review dates of when these were placed Review indications for removal and/or replacement on daily basis				

	Daily Checklist				
FEN/GI	 IV fluids (put end-time/total amount and review daily) Indications for NPO □ Upcoming procedure □ PET scan (also avoid dextrose-containing IV fluids – review all IV meds) □ Concern for aspiration of all PO intake (including medications) □ Avoid caffeine prior to regadenoson stress testing^a 				
DVT prophylaxis ^b	 □ SCDs □ Enoxaparin subQ if CrCl >30 (hold 24 hours before most procedures) □ Heparin subQ if CrCl <30 (hold 12 hours before most procedures) □ Contraindications: active bleeding, low platelet count, 				
Stress ulcer prophylaxis ^c	Indications (for critically ill patients) ☐ On mechanical ventilator for ≥48 hours ☐ Coagulopathy (INR >1.5, plt <50) ☐ High-dose/chronic steroid or NSAID use ☐ Recent GI bleed				
Code status ^d	Options include: Full, DNR/never intubate, DNR/okay to intubate, compressions okay/never intubate				

Disposition Checklist

- ☐ Update family/DPOA on status of patient
- ☐ Fill out/update POLST form (if indicated)
- ☐ Post-hospitalization living situation
- ☐ Insurance for meds (prior authorization) and nursing homes
- ☐ Post-discharge transportation
- Equipment at home for safety/function
- Outpatient referrals and appointments
- ☐ Consider need for prescriptions (new medications, refills)
- ☐ Discharge medication education
- Discharge summary (include pending inpatient labs that require outpatient follow-up)
- ☐ Outpatient labs (if needed) and identify provider responsible for results
- ☐ Handoff communication to accepting provider (PCP, SNFist, etc.)

- a. Some centers require patients to be NPO prior to stress test simply due to policy
- b. The FDA has approved some DOACs and fondaparinux as options as well
- c. If a patient is on long-standing PPI or H₂-blocker therapy which cannot be discontinued due to symptoms or specific medical indication, this will suffice as stress ulcer prophylaxis. Consider de-prescribing if no indication
- d. At the VA, patients cannot legally have mixed code status (if pulseless, patients must be Full Code or DNR/never intubate)



ncrete steps D H D H D G M CO A H D H D H D H D H D H D H D H D H D H	Patient being actively arrhythmias from electronal Patient-specific How does my patient's care differ rom typical management of common issues?	diuresed for volume overload, anticipate rolytes" "Patient had cardiac arrest after beta blocker use, so if patient goes into A-fib with RVR, consider amiodarone" "Patient has an EF of 15% so be cautious with
H pa	How does my patient's care differ rom typical management of	use, so if patient goes into A-fib with RVR, consider amiodarone"
be tir	Accelerated nanagement What information can be related to save ime and accelerate care for the patient?	"Patient with QTc of 560, if nauseous, try trimethobenzamide or low-dose lorazepam" "Patient prefers omeprazole over lansoprazole"
Contingencies	Recent procedure and relevant complications ogistical considerations	"Patient s/p ERCP, pancreatitis can occur" "Patient may need urgent IR intervention overnight, here is the number for the on-call IR fellow" "Patient lacks capacity to make decisions

Signouts are considered part of medical records

Conversing with a Consultant				
Preparation	Determine the consult question			
	Obtain relevant information from the chart/patient			
	Introduce yourself and your role clearly			
Presentation	Deliver a concise relevant one-liner			
Presentation	Always provide context			
	Be honest			
Plan of Action	Review steps that have been taken so far			
	Formulate next steps with your consultant			

"Hello, I am the resident on the inpatient medicine service, and I am here with my attending. We have a young patient with no past medical history who has been reporting melena for the past week and their Hgb is currently 10 g/dL (baseline of 14 g/dL based on chart review). We have not witnessed the melena and the patient just had a bowel movement, but we forgot to notify them to not flush it for us to examine it. We placed 2 large-bore peripheral IVs, completed a type and screen, are giving IV fluids, and started a PPI IV BID due to suspicion for upper GI bleed. Is an inpatient EGD appropriate? Are there additional steps that we should be taking right now? FYI the patient is expressing a desire to leave tomorrow as they are the sole caregiver for their children."

Some institutions have auto-consults (e.g., all with Type 1 Diabetes Mellitus automatically get an inpatient endocrinology consult); even so, make sure to do your due diligence before reaching out to the consultant



	Anti-Emetic Regimen Guide						
Class	Medication	Route	Common Side Effects	QT-Prolongation			
Serotonin	Ondansetron (Zofran)	PO, IVP, IM, sublingual		✓			
antagonists	Granisetron (Kytril, Sancuso)	PO, IV, transdermal	Headache, constipation, drowsiness, diarrhea	✓			
	Metoclopramide (Reglan)	PO, IVP, IM	Drowsiness, EPS, do not use if increased GI motility	√			
	Olanzapine (Zyprexa)	PO, IM, sublingual	EPS, hyperglycemia	\checkmark			
Dopamine (DA) antagonists	Prochlorperazine (Compazine)	PO, IVP, PR	EPS, NMS	√			
	Haloperidol (Haldol)	PO, IM	EPS, constipation, dry mouth, blurred vision, somnolence	√			
	Chlorpromazine (Thorazine)	IM, IV	EPS, dry mouth	√			
Histamine antagonists	Diphenhydramine (Benadryl)	PO, IVPB, IVP	Dizziness, drowsiness, paradoxical excitation	✓			
ACh antagonists	Scopolamine	PO, IVP, IM, transdermal	Bradycardia, flushing, thirst, xerostomia, urinary retention	√			
DA/Histamine/ACh antagonist	Promethazine (Phenergan)	PO, PR, IVP, IM	EPS, NMS, drowsiness, sedation, leukopenia, thrombocytopenia	✓			
Nourokinin 1/NK 1)	Aprepitant (Emend)	РО	Hiccups, bradycardia, neutropenia				
Neurokinin-1(NK-1) Fosaprepitant (Ivemend)		IV	Angioedema, bradycardia, neutropenia				
	Dexamethasone	PO, IVP, IM	Leukocytosis, mood changes, adrenal suppression, hyperglycemia				
Centrally acting	Trimethobenzamide (Tigan)	PO, IM	EPS, disorientation, seizure				
	THC, dronabinol	PO	Hyperemesis, tachycardia, nystagmus, ataxia				
	Lorazepam (Ativan)	PO, IVP, IM	Respiratory depression				

Bowel Regimen Guide					
Class (Mechanism)	Medication	Side Effects			
	Polyethylene glycol	Nausea, bloating, cramping			
Osmotic agents	Lactulose	Abdominal bloating, flatulence			
(draws water into bowel,	Sorbitol	Abdominal bloating, natulence			
thereby loosening stool and	Glycerin	Rectal irritation			
promoting evacuation)	Magnesium sulfate PO	Watery stools and urganov			
,	Magnesium citrate	Watery stools and urgency			
Stimulant laxatives	Bisacodyl	Rectal irritation			
Sumulant laxatives	Senna	Melanosis coli			
Bulk-forming laxatives (fiber absorbs excess water and stimulates elimination)	Psyllium	Impaction above strictures, fluid overload, gas, and bloating			
Rectal distension	Tap water enema Fleet enema*	Discomfort during procedure			

Avoid docusate as it does not help with constipation in hospitalized patients^a

*Fleet enemas contain phosphate and should be avoided in renal insufficiency

a. Robert J Fakheri, MD, Frank M Volpicelli, MD, Things We Do for No Reason: Prescribing Docusate for Constipation in Hospitalized Adults. *J. Hosp. Med* 2019;2;110-113. doi:10.12788/jhm.3124



Pharmacologic Pain Management Options				
Class	Options			
Anti-inflammatory	Acetaminophen (24 hours: <3-4g in healthy adults, <3g in CKD, <2g in liver disease or cirrhosis) Oral NSAIDs or IV ketorolac (avoid NSAIDs if CKD or >2 of the following risk factors: history of GI ulcer, age >60, on steroids, on ASA/anticoagulation)			
Opioid	Hydrocodone, morphine, oxycodone, hydromorphone, fentanyl, tramadol, codeine			
Topical	Lidocaine patch, menthol cream, lidocaine/prilocaine cream, capsaicin cream			
Neuropathic agents	Gabapentin, pregabalin, SNRIs, TCAs			
Anti-spasmodic	Baclofen, cyclobenzaprine, tizanidine			

Opioid Conversion Table ^{a,b,c}							
Opioid	Equianalgesi	c dosing (mg)	Onset	Peak	4	Considerations	
Opiola	IV, SC, IM	РО	Oliset	reak	t _{1/2}	Considerations	
Morphine	10	25	IV: 5-10m PO: 30m	IV: 15m PO: 60m	2-4h	Avoid in renal failure, active metabolites	
Hydromorphone	2	5	IV: 5m PO: 30m	IV: 10-20m PO: 60m	2-3h	Reduce dosing in hepatic dysfunction	
Oxycodone	N/A	20	10-30m	1-2h	3-4h	Caution in hepatic dysfunction	
Hydrocodone	N/A	25	10-30m	m 1-2h 4h Caution in hepa		Caution in hepatic dysfunction	
Fentanyl	0.15	n/a	1.5m	IV: 5-10min	2h	Preferred for hepatic/renal failure	
Tramadol	N/A	120	1h	2h	6-8h	Risk for serotonin syndrome Can ↓ seizure threshold	
Codeine	N/A	200	30m-1h	1-1.5h	3h	Prodrug metabolized to morphine in liver, variable metabolism	

Buprenorphine/Naloxone (Suboxone) Pearlsd

Always continue in patients who have been taking prior to admission

If patient develops acute pain while on the medication, **split the same total daily** dose into q12h – q6h to utilize buprenorphine's analgesic window

If patient continues to have pain,
discuss ↑ total daily dose OR
add a high-affinity full μ agonist
(such as hydromorphone or fentanyl)
with assistance from pain medicine/
addiction medicine

Continue this medication in the peri-operative setting;

doses >16mg/day may be decreased in discussion with pain medicine

Discuss starting this medication with all hospitalized patients with opioid use disorder

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a. Different tables will reference different values. This table uses McPherson (Demystifying Opioid Conversion Calculations: A Guide for Effective Dosing, 2nd Edition by Dr. Mary Lynn McPherson PharmD, BCPS, CPE), while others utilize CDC guidance. Choose one and stick with it.

b. When rotating opioids, consider reducing equivalent dose by 25-50% to account for incomplete cross tolerance

c. If patients with renal failure, consider fentanyl, methadone or hydromorphone. Avoid morphine due to renally cleared metabolites

d. Kohan L, Potru S, Barreveld AM, Sprintz M, Lane O, Aryal A, Émerick T, Dopp A, Chhay S, Viscusi E. Buprenorphine management in the perioperative period: educational review and recommendations from a multisociety expert panel. Reg Anesth Pain Med. 2021 Oct;46(10):840-859. doi: 10.1136/rapm-2021-103007. Epub 2021 Aug 12. PMID: 34385292.

Inpatient Blood Pressure Management Guide						
Class	Route		Frequently Used Agents	Relative/Absolute Contraindications	Effect on	
Class	РО	IV	Trequently Osed Agents	Relative/Absolute Contraindications	ICP	
β-blockers	√	✓	Metoprolol, Carvedilol, Labetalol	Bradycardia, heart block, ADHF, COPD exacerbation	\leftrightarrow	
ACEI/ARBs	√	√	Captopril, Enalaprilat (IV), Lisinopril, Valsartan	AKI, hyperkalemia, angioedema	\leftrightarrow	
α2 agonists ^a	\checkmark	✓	Clonidine	Severe bradycardia	\leftrightarrow	
Nitratesa	\checkmark	\checkmark	Isosorbide dinitrate	Severe AS, PDE inhibitor use	1	
CCBsb	√	✓	Nifedipine ER, Diltiazem, Amlodipine	HFrEF For non-dihydropyridines: Bradycardia, heart block	\leftrightarrow	
Diuretics	✓	✓	Chlorthalidone, Hydrochlorothiazide, Spironolactone	AKI, hypovolemia, difficulty with transferring to urinate	↓	
Vasodilators	\checkmark	✓	Hydralazine	Can develop severe reflex tachycardia due to the	<u> </u>	
Non-selective α blockers		✓	Phentolamine	unpredictable drop in SBP	\	
Partial D1 agonists		✓	Fenoldopam	Glaucoma	↑	

Avoid acute treatment of asymptomatic severe hypertension (formerly known as hypertensive urgency)^c

- a. Transdermal formulation is available
- b. Amlodipine takes approximately 30 hours to become effective
- c. Breu AC, Axon RN, Acute Treatment of Hypertensive Urgency. *J. Hosp. Med* 2018;12;860-862. Published online first October 31, 2018. doi:10.12788/jhm.3086



IV Fluid Timeout ^a						
Step 1: Indication	Step: 2 Approach	Step 3: Type of fluid ^b	Step 4: Amount of fluid			
Low preload state leading to vital sign changes +/- symptoms	Resuscitation	Colloids are not superior to crystalloids LR and Plasma-Lyte can be given in hyperkalemia You cannot rely on serum lactate levels if you give LR to a patient with cirrhosis If increased ICP, consider using Plasma-Lyte instead of LR	Give IV fluids (in 250-1000 mL increments) and re-assess volume status In sepsis, consider 20-30 mL/kg (use extra caution with heart failure, renal failure and cirrhosis)			
Disrupted oral intake	Maintenance	0.45% NS with 5% dextrose	Calculate amount using "4-2-1" rule			

Electrolyte Repletion Guide						
Electrolyte	Amount	Route	Details			
Potassium (ref range 3.5-4.5)	$\frac{Goal K - Actual K}{Creatinine^{c}} \times 100 = mEq \text{ of KCI}$	Oral, IV (10 mEq/hr peripherally, 20 mEq/hr centrally) KCI	>4 if acute MI, cardiac conditions >4.5 if VT			
Magnesium (ref range 1.3-1.7)	$\frac{GoalMg - ActualMg}{Creatinine^c} \times 10 = gm \text{ of MgSO}_4$	Oral (MgO causes diarrhea, Mg- protein complex does not cause diarrhea), IV MgSO ₄	>2 if CAD or active cardiac conditions >2.5 for VT			
Calcium (ref range 8-10)	1 gm at a time	IV calcium carbonate	No need to replete unless symptomatic or if QT prolongation			
Phosphate (ref range 2.5-4.5)	See table below	Oral, IV	Pay attention to K load			

	Phosphate Repletion Guided						
		D					
Route	Formulation	Phos <1.5	Phos 1.5-1.9	Phos 2-2.5	Amount of K		
	Neutra-Phos	2 packets	1-2 packets	1 packet	7.1 mEq per packet		
Oral	Neutra-Phos-K	2 packets	1-2 packets	1 packet	14.3 mEq per packet		
	K-Phos Neutral (Na and K Phos)	2 tablets q4h x4 doses	2 tablets q4h x3 doses	2 tablets q4h x2 doses	1.1 mEq per tablet		
IV	Potassium Phosphate	18-21 mmol	12-15 mmol	9-12 mmol	4.4 mEq per 3 mmol phos		
	Sodium phosphate	18-21 mmol	15 mmol	9-12 mmol	0 mEq		

- a. Consider aggressive IV fluids for nephroprotection in specific situations (e.g., tumor lysis, hypercalcemia, etc.)b. For a table on options for considerations for crystalloids, go to bit.ly/crystalloids (case-sensitive)
- c. If creatinine is <1, just divide by 1
- d. If CrCl <30, divide dose by 50%

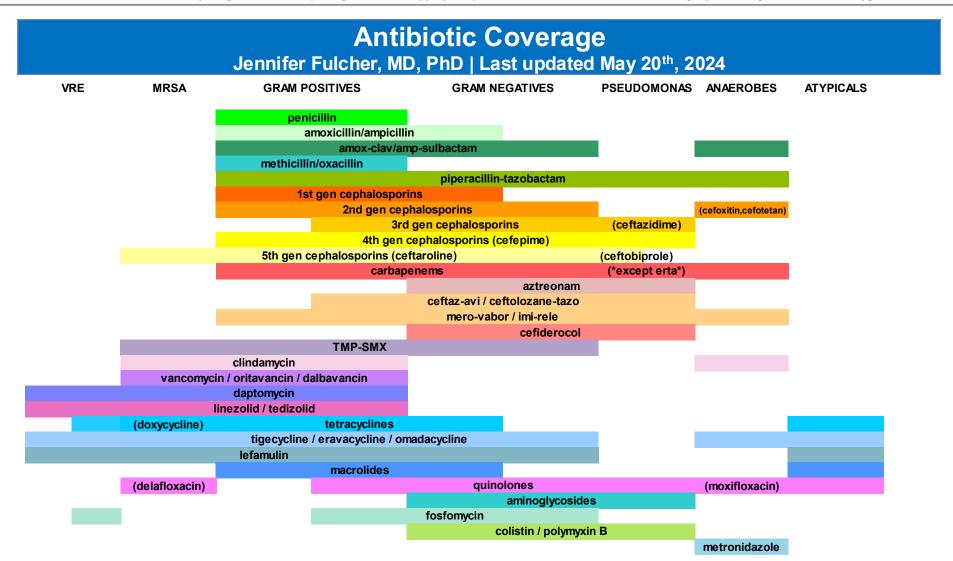


Antimicrobial Stewardship

What syndrome? (e.g., UTI, bacteremia, etc.)
What bug? (Use culture data. If none, what is most likely?)

What drug? (IV or PO?) Check local antibiogram Initial duration of therapy? Can I de-escalate? If on IV, can I switch to PO? Can I stop? (Use clinical data like vitals, WBC count, and cultures to tailor therapy) Discharge patient
Confirm type of IV access (if indicated) and if frequency of
medication and lab followup is feasible at discharge destination)

Check the dose, frequency, and duration (renally dose when appropriate). For duration, be sure to account for any inpatient days of effective therapy.



Туре	2 Diabetes	Mellitus Inpatient Medication	Guidea
Class	Examples	When to hold?	If NPO, ↑ risk of hypoglycemia?
Biguanide	Metformin	Lactic acidosis ↑ risk of developing AKI GFR <30	No
Sulfonylurea	Glipizide	↓ or variable oral intake GFR <30	Yes
TZD	Pioglitazone Rosiglitazone	Risk of heart failure or MI ALT >2.5x ULN	No
DPP-4 inhibitor	Alogliptin Saxagliptin	Prior or current pancreatitis Avoid saxagliptin in heart failure	No
GLP-1 receptor agonist	Dulaglutide Liraglutide Semaglutide	Hold pre-operatively for 1 day (if dosed daily) or for 1 week (if dosed weekly) Prior or current pancreatitis Nausea and/or vomiting Ileus or gastric dysmotility	No
SGLT2i	Empagliflozin Dapagliflozin	Hold pre-operatively for 72 hours ↓ or variable oral intake Hypovolemia	No*
Meglitinide	Repaglinide	NPO	Yes
α-glucosidase inhibitor	Acarbose Miglitol	Cirrhosis Partial bowel obstruction Cr >2	No

*Increased risk of euglycemic DKA

Calculate total daily dose of insulin and adjust appropriately

Weight-based insulin
0.3-0.6 units/kg/day
~50% basal + ~50% mealtime

If NPO, stop mealtime insulin and reduce basal insulin by ~20%

Never completely discontinue basal insulin in Type 1 Diabetes Mellitus

Assess for presence of insulin pumps and continuous glucose monitors in Type 1 Diabetes Mellitus

If sliding scale insulin requirements are minimal, consider discontinuing it completely

Adjust insulin dose for renal dysfunction and older age

Inpatient blood glucose goal 140 – 180 mg/dL^b



Insulin Pearls

a. "Oral Diabetes Medications Inpatient: Mind the Gap Series." coreimpodcast.com. Patel, S., Trivedi, S., Umpierrez, G., Troy, A., Larsen, T. October 13, 2021. https://www.coreimpodcast.com/2021/10/13/oral-diabetes-medications-in-hospitalization-mind-the-gap-segment/

b. Nice-Sugar Study Investigators. "Intensive versus conventional glucose control in critically ill patients." *New England Journal of Medicine* 360.13 (2009): 1283-1297.

	Setting			Details	Minimum functional status	Admission requires
	Intensive Care Unit (ICU)		nit (ICU)	On mechanical ventilation, pressors, q1-2h checks/interventions		
		ate Care/Ste _l ssive Care U	p-Down Unit/ Init (PCU)	On NIPPV, continuous drips		
	Long-Te	erm Acute Ca	are (LTAC)	Stable on ICU/PCU level of care		Insurance
Care	Med-surg	Inpa	tient status	Hospitalized, needing cardiac monitoring and/or pulse oximetry, q4h checks/interventions		
of Ca	± telemetry	Observation	ı status	Hospitalized, needing cardiac monitoring and/or pulse oximetry, q4h checks/interventions, anticipated discharge within 72h (or 2 midnights for Medicare)		
<u>a</u>	Skilled	Sh	ort term	Skilled need ^a		
Leve	Nursing Long term Wenderquerd		Wanderguard	Custodial care ^b with varying degrees of security based on ability to elope and safety risk if elopement occurs		Insurance
Escalating	Acute Rehabilitation Unit (ARU)		Unit (ARU)	≥3h of PT/OT per day	Independent (or have someone available to assist) in iADLs	Insurance
<u>a</u>	Residential Ca	are Secure	d (Memory)	Long-term housing, meals, and assistance with	Independent in ADLs	
sca	Facility for the Elderly (RCFE) ^c		cured	medication self-administration, but no skilled needs provided	Independent in ADLs/iADLs	Money
ш	Substance rehabilitation		ilitation	Facilities with daily group programs	Independent in ADLs/iADLs	Insurance or money
	Recuperative care		care	For patients experiencing homelessness (services such as physical therapy, addiction therapy, and wound care can be done through home health)	Independent in ADLs/iADLs	
	S	ection-8 Hou	ısing	Long-term subsidized housing	Independent in ADLs/iADLs	Money
		Shelter		Conducts medical care by self	Independent in ADLs	
	Home <u>+</u> home health		nealth	Care by self <u>+</u> help from family/friends/caregivers		

a. Medicare defines skilled need as IV antibiotics, daily complex wound care, speech therapy, PT/OT, first-time tube feeds comprising >26% of daily nutritional need



b. Medicare defines custodial care as care that helps you with usual daily activities, like getting in and out of bed, eating, bathing, dressing, and using the bathroom. It may also include care that most people do themselves, like using eye drops, oxygen, and taking care of colostomy or bladder catheters.

c. Includes Board & Care (B&C) and Assisted Living Facility (ALF)

d. Some RCFEs can accommodate ADL dependence for an additional fee

Inpatient Pocket Cards



For an effective conversation, you must **match** the type of conversation your patient is trying to have with you.

	Matching Communication Types ^a				
Туре	Purpose	Clues to identify type of conversation	Sample phrases to engage	Risk if mismatched	
Emotional	To express or process feelings and for others to see what they are experiencing	"Why is this happening to me?" Same question is repeated after a clear answer You feel stuck or unsure how to respond	"That sounds really hard" "This feels like a lot to carry" "Thanks for sharing that. I want to understand better"	They feel dismissed or unheard if given facts too soon	
Practical	To understand, plan, or make a decision	Logistical questions Patient is trying to make a decision	"Here's what we know so far" "We're still waiting on [test, consult, etc.]" "What questions do you have? I want this to feel clear"	They feel frustrated if met only with empathy or vagueness	

Coi	Communicating Uncertainty ^b				
The GAP	Scen	enarios			
framework can help if clinical trajectory or next steps are unclear	Diagnostic (Patient with fevers despite extensive workup and is asking for a medical update.)	Prognostic (Patient with recent brain bleed, family wants to know if he will return to baseline.)			
Given (what we know)	"You've had fevers, and your labs suggest inflammation, but common causes have been ruled out."	"We know the bleeding in their brain has stopped and they're stable right now."			
Ambiguous (what we don't know)	"We don't know yet what's causing your symptoms. Some test results are still pending."	"We're not sure how much of their thinking and strength will return over time."			
Plan (what we will do)	"We're reviewing more specialized labs and consulting rheumatology to help us figure this out."	"We'll monitor them closely and involve rehab specialists to guide the next steps."			

a. Duhigg, C. The science behind dramatically better conversations. [Video] TED Conferences. 2024 Mar. http://www.ted.com/talks/charles_duhigg_the_science_behind_dramatically_better_conversations _ may_2025 b. Dahm MR, Cattanach W, Williams M, Basseal JM, Gleason K, Crock C. Communication of Diagnostic Uncertainty in Primary Care and Its Impact on Patient Experience: an Integrative Systematic Review. J Gen Intern Med. 2023 Feb;38(3):738-754. doi: 10.1007/s11606-022-07768-y. Epub 2022 Sep 20. PMID: 36127538

	Communicating Code Status				
	Scenarios				
The CLEAR framework can help guide code status conversations	Clinical Decompensation (Patient with end-stage HFrEF, now on BPAP and borderline hypotension, showing signs of rapid decline.)	Discordant Goals or Wishes (Patient with metastatic cancer, with multi- organ failure, insists on being full code despite poor prognosis.)			
Curiosity (explore goals, concerns, and values)	"When you think about everything you've been through recently, what feels most important to you right now?"	"Can you help me understand what you're hoping for?"			
Language (use words that reflect values)	"We can use machines to support your breathing, but they may not help you recover."	"Some treatments might prolong life but not improve quality or function."			
Empathy (acknowledge emotional experience)	"This must be overwhelming, we're here with you."	"I can see how hard this is for you and your family."			
Assurance (provide comfort, normalize fears, and ensure continuity)	"Whatever you decide, we're going to make sure you're cared for and not in any discomfort."	"We'll stay with you and support you, even if we see things differently."			
Recommendation (align care recommendations with what matters most)	"Given what's happening and what's most important to you, I'd recommend comfort and time with loved ones."	"Considering your goals, I'd recommend avoiding treatments that won't help you recover."			

Inpatient Pocket Cards



Primer on Access and Tubes

Review daily and try to remove them ASAP when appropriate Brand names are listed for recognition and are not an endorsement of a specific product

	Venous Access				
Name	Indication	Replace every	Details/Complications		
Peripheral IV	Short-term access	3-4 days	Infiltration, phlebitis		
Midline	Intermediate access	6-14 days	Cannot administer vesicants (eg vancomycin, calcium chloride, IV contrast)		
Peripherally- inserted central catheter (PICC)	Long-term IV access (TPN, antibiotics)	Weeks to months	Malposition, infection		
Non-tunneled central venous catheter (CVC), central line*	ICU medications, CVP assessment, emergent access	2-3 weeks	Cannot advance the line if insufficiently inserted. CRBSI risk (femoral > IJ > subclavian)		
Tunneled central venous catheter (Hickman)	Long-term IV access (chemotherapy, TPN, antibiotics)	Months to years	Reduced infection risk, mechanical complications (dislodgement)		
Implantable port (Port-a-cath)	Long-term intermittent IV access (chemotherapy, TPN, antibiotics)	Indefinite (if working)	Reduced infection risk, fully subcutaneous		

Dialysis Access				
Name	Indication	Replace every	Complications	
Non-tunneled dialysis catheter (Quinton)	Temporary HD	2-3 weeks	CRBSI risk (femoral > IJ > subclavian)	
Non-tunneled CVC + dialysis catheter (Trialysis)	Temporary HD, ICU medications	2-3 weeks	CRBSI risk (femoral > IJ > subclavian)	
Tunneled dialysis catheter (Perma-Cath)	Long-term HD	Indefinite	Reduced infection risk	

^{*}Usually one lumen (Cordis) or three lumens (triple lumen)

		Enteric Tube	es e
Name	Indication	Replace every	Details/Complications
Nasogastric Tube (NGT)	Decompression, lavage, medication/feeding access	5-7 days	Can coil in the esophagus/stomach or go into the lungs,
Small-bore NGT (Dobhoff)	Post-pyloric enteral feeding	4-6 weeks	confirm placement with imaging
Orogastric Tube (OG Tube)	Decompression, medication, feeding	5-7 days	Often used in intubated or facial trauma patients, not tolerated awake
Percutaneous Endoscopic Gastrotomy (PEG) Tube / G-tube	Long-term gastric feeding	3-6 months	Early dislodgement can lead to peritonitis, wait ≥4 weeks before exchanging. Placed by GI or IR if no overlying bowel, otherwise placed by general surgery
Naso- Oro-Jejunal tube (NJ-, OJ-tube)	Jejunal feeding	3-6 months	Subtle dislodgement, for continuous feeds only
Jejunostomy tubes (J-tube, PEJ)	Long-term nutrition with gastric dysfunction and ↑ aspiration risk	6-12 months	Subtle dislodgement, for continuous feeds only
Gastrojejunostomy tubes (GJ tube)	Jejunal feeding and gastric venting/decompression	6-12 months	Balloon overinflation can cause mucosal damage Avoid in neutropenia, rectal pathology
Rectal Tube (Flexi-Seal)	Divert liquid stool, protect skin, monitor output	1 month	Avoid in neutropenia, rectal pathology; not effective for formed stool

Genitourinary Tract Tubes				
Name	Indication	Replace every	Details/Complications	
Condom catheter	Urinary incontinence	Daily	Leakage, dislodgement, penile skin breakdown. Use correct size; apply to clean, dry skin; never for retention	
Urinary catheter (Foley)	Urinary retention, I/O measurement	4-6 weeks	Obstruction, UTI, traction injury If acute indication, attempt voiding trial ASAP	
Suprapubic catheter	Long-term urinary diversion	4-6 weeks (by urology)	Tract closure if pulled early, requires trained team for reinsertion	
Nephrostomy tube	Ureteral obstruction or diversion	6-12 weeks (by IR)	Leakage, dislodgement	

Thoracic Tubes					
Name	Indication	Replace every	Details/Complications		
Chest tube (16-28 Fr)	Effusion, hemothorax, pneumothorax	Per clinical indication	Confirm placement on imaging		
Pigtail catheter (14 Fr)	Pneumothorax, effusion	Until output ↓	Clogs easily, secure dressing		
Tunneled pleural catheter (PleurX)	Recurrent effusions or ascites	Indefinite	Requires home teaching		

Problem Representation

An evolving summary of a patient's clinical presentation that strives to identify (1) Clinical syndrome (signs/symptoms), (2) Context (relevant history/demographics), and (3) Temporal pattern to maximize diagnostic signal.

Component	Detail	Examples
What are they experiencing? (clinical syndrome)	Chief concern forms the first clinical syndrome Translate your patients' story into medical terminology Highlight the relevant clinical findings	Chest pressure and short of breath when I walk → angina Fever, tachycardia, leukocytosis → SIRS
Who is the patient? (context)	Use a patient's <u>relevant</u> epidemiology, medical, social, family, and exposure history as a framing tool	Age: 84-year-old with melena vs 24-year-old with melena Biological sex: male with RLQ pain vs female with RLQ pain Risk factors: patient with HTN and DM p/w chest pain vs patient on oral contraception p/w chest pain
When is this happening? (temporal pattern)	The temporal pattern of presentation is a key distinguishing feature that helps build and prioritize the differential diagnosis	Acute, subacute, chronic, sudden-onset Episodic, progressive Waxing, waning

Example problem representation

Middle-aged female with diabetes and GERD presents with acute progressive angina, elevated troponin x2, and inferior 2mm ST depressions.

Tips for making an effective problem representation

Use semantic qualifiers

Use words to characterize signs and Sh symptoms

acute vs chronic
sharp vs dull
episodic vs constant
proximal vs distal
static vs progressive
painful vs painless

Keep it updated

Should evolve with new data

An elderly male with acute hypoxic respiratory failure from community acquired pneumonia → An elderly male with improving community-acquired pneumonia now found to have acute diarrhea

Lower the cognitive load

Translate and abstract data into clinical syndrome

Pain with inspiration → pleuritic

Fevers, cough, CXR infiltrate, hypoxia, tachycardia, hypotension, leukocytosis, positive sputum culture with S. aureus → Severe sepsis from MSSA pneumonia

When to use?

One-liner at start of Assessment and Plan

Calling a consultant

Signing out a patient for cross coverage

Educating a team at a rapid response

Inpatient Pocket Cards



Keep trying – if difficulty with arriving at a diagnosis, change the input to see if it changes the output