CTU Admission Structure

Admissions for CTU Teams

Call Structure for CTUs A-D&G
- “On-Call” starts for CTU A-D&G teams at 1pm M-F and noon weekends/holiday
- Call continues until 8am post-call day
- The “on call” team is divided between teams on a rotating basis 1:5
- The “Primary on-call” team will consist of the Attending and Senior Resident (until 10pm) and Junior (either R1 or CC) from the same team (e.g. CTU A).
- In addition, there will be a junior trainee (CC/R1) from each of 3 other teams, as well as a senior resident from an unassigned team (Extra ER). The Extra ER will admit to the CTU team that does not have a junior. All trainees should admit only to their own teams, with the exception of E.
  • Continuity of care trumps equality of numbers!
- The Night Float senior starts at 10pm, the on-call seniors go home but the R1 and Clerks stay overnight.

Example

<table>
<thead>
<tr>
<th>Day 1:</th>
<th>Trainees</th>
<th>Attending on-call</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 2:</td>
<td>CTU A Senior / 2R1 &amp; 2CC for teams CTU A, B, C, D / Extra ER (G)</td>
<td>CTU A</td>
</tr>
<tr>
<td>Day 3:</td>
<td>CTU B Senior / 2R1 &amp; 2CC for teams CTU B, C, D, G / Extra ER (A)</td>
<td>CTU B</td>
</tr>
<tr>
<td>Day 4:</td>
<td>CTU C Senior / 2R1 &amp; 2CC for teams CTU C, D, G, A / Extra ER (B)</td>
<td>CTU C</td>
</tr>
<tr>
<td>Day 5:</td>
<td>CTU D Senior / 2R1 &amp; 2CC for teams CTU D, G, A, B / Extra ER (C)</td>
<td>CTU D</td>
</tr>
<tr>
<td>Day 6:</td>
<td>CTU G Senior / 2R1 &amp; 2CC for teams CTU G, A, B, C / Extra ER (D)</td>
<td>CTU G</td>
</tr>
</tbody>
</table>

Then repeats...

Rules
- Admissions should be divided up on a 1:1 basis between teams with priority to keep patients within the team whenever possible to allow continuity of care (i.e. the R1 and student should be presenting to their own attending and continue to look after their new admissions).
- D4ICU patients are preferentially reviewed by the on-call attending, but admitted to the junior’s team who initially saw the case.
- Appropriate ‘medicine short stay’ (MSSU) patients should be directly admitted to CTU E team on MSSU (C3)
- Unseen patients from overnight are handed over to the CTU E in am
- On call Interns and Clerks should be released from seeing new consults at 6am in order to round on their patients between 6-8am.
- Night Float resident is responsible for new consults between 6-8am.

Reviewed October 2020
Admission Rules for CTU E/Medicine Short Stay Unit (MSSU) Team

- CTU E has a **20 patient cap**, typically has a census of 10-15 patients
- CTU E will accept all appropriate short stay patients (see separate document for guidelines) whatever the time of day/night.

Daytime Admissions from ED
- CTU E covers any left-over consults and all new ED consults from 8am-1pm (M-F) and 8am-noon (weekends & holidays)
- Any patients deemed NOT appropriate for the MSSU are assigned to a CTU A-D&G team and admission orders are completed. These patients are reviewed with the CTU E attending or the A-D&G attending if they are available.
  - Transfer of care to receiving team occurs when patient goes up to the ward OR at 1pm, whichever comes first
- On-call CTU teams (A-D&G) can directly admit to CTU E / MSSU beds either by reviewing with their own staff on call nights or with the CTU E attending

Other sources of CTU Admissions
- ICU transfers (from K2ICU)
- Transfers approved by GIM consult / Medicine subspecialty services
- Direct to medicine wards from clinics
- Direct to medicine wards from outside hospitals
- Transfers from IMU H
- Transfers from CTU E (short stay that declare as long admissions)
- Transfers ideally should be allocated by bed location on ‘home’ wards if possible (e.g. C10 go to A/B teams, K10 to A/B, C9 to C/D teams, K9 to C/D team, C3 or D5 to G).
  - Direct transfer into D4ICU should ideally go to the Primary on-call team

“Bounce-Back” Rules
- “Bounce-Backs” belong to original CTU team (if discharged and readmitted within the same block – starting day 1 [i.e. first Tuesday of the block])
  - The block refers to the residents’ 4 week period
- ICU “Bounce-Backs” belong to CTU team that transferred into ICU (if in & out within same block, assuming the patient was reviewed by an Attending prior to ICU transfer)
- IMU H “Bounce-Backs” belong to CTU team that transferred to IMU H (if in & out within same block)
- “Bounce-Backs” do NOT count to patient team # on call
- Ideally the patient should be seen by the junior on call from the team who will be re-admitting the patient
“Holdovers”: Direct Discharges from ED/Patients not appropriate for Medicine Admission

- Patients can be directly discharged home by Medicine from the ED, or ‘held-over’ for staff review if the residents feel that the patient would be best served by an admitting service other than medicine
- All discharges NEED to be discussed with an Attending Physician with documentation that the discussion occurred
- Juniors should review these cases directly with their OWN attending
- #3 should be dictated to document the encounter for patients being discharged

KGH Admission Algorithm

- All Medicine Residents and Attendings should be familiar with this document
- Helps avoid confrontations and outlines the appropriate admitting services for most diagnoses

Post Call Rounds

- Start 7:30am-8am in section A of the ER, or in Team rooms to review.

Attending Expectations:

- All new admissions MUST have a Staff Attending Note within 24hrs/admission
- Primary on-call Attendings are encouraged to visit the ED on call evenings and must write admission/consult notes for their own team’s patients. They may review patients appropriate for the CTU E/MSSU team or D4 admissions to other teams.
- Primary on-call Attendings should supervise/assist trainees on the other teams if needed – these patients will get a full review & staff note from their own Attending in the am
- Post-call mornings all Attendings will review patients not previously seen
- Primary on-call Attending MUST cover the ED on Wednesday AHD 1-4pm
- An Attending presence is expected each weekend on service