Handbook

for

Attending Staff
on the Clinical Teaching Units (CTUs)

Kingston General Hospital

Department of Medicine
Queen's University

October 2020

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CTU Attending Expectations

Different Attending staff like to run their teams and rounds slightly differently, and the daily schedule will vary based on how busy a service is, but there are a few basic expectations . . .

1. All new admissions are seen and have a Staff Attending note within 24 hours of admission
    a. Preferably on the yellow consult sheet; if none is filled out by ER, please still complete one (this is scanned into EMR)

2. Patients in D4ICU are reviewed daily in D4ICU with the senior resident

3. Maximum of 1 half day clinic/procedures per week while on CTU
    a. Attending must be available afternoons on call
    b. Attending must be available mornings to review new admissions
    c. Attending must be available to answer calls/pages from the nurses and address urgent issues during Core Academic Half Day (Wednesday and Thursday afternoons, 1-4pm, or 2-5pm)

4. Bedside rounds should occur at least once weekly
    a. Not necessary to round on all patients on the team, but some form of team-based bedside rounding with teaching

5. Attending to Attending handover must occur at the end of each two week block
    a. Ideally the 'Resident Handover Tool' in PCS is reviewed by the attending prior to handover

6. Attendings are expected to go to the ER on their evenings / nights on call to help senior residents send home patients who can be discharged and to review urgent consults and D4ICU admissions to help patient flow

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7. Attendings are expected to give verbal feedback to all trainees on the team at the end of their block of MRP.
    a. Attendings are required to be present for 'Feedback Monday': every second Monday from 12-1pm when group feedback is collected for CBME purposes
    b. Attendings are expected to complete CBME forms for IM residents, both field notes and PPA forms

8. Attendings **MUST** release all post call clerks and residents by **10am at the latest** on their post call day.

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CTU Team Structure

CTUs A – D & G

Team Structure and Location

Each of the five ward CTU teams consists of two senior residents (typically an IM R3 & R2), two R1s (a mix of IM and off-service residents), and two clinical clerks (medical students in their third or fourth year and occasionally an elective medical student). With a drip system, you will always have 1 post call trainee and other trainee absences related to vacation, academic leave, etc. Team sizes usually run in the 20 – 30 patient range, but do fluctuate. There is no cap on team sizes.

Each of the CTUs A, B, C, D & G have an associated **Patient Care Navigator**, a RN whose role is to help facilitate discharge planning, allied health co-ordination, paperwork for rehab or homecare applications, family discussions and any complicated disposition issues. They are an invaluable resource for information and assistance.

The teams are mostly geographically consolidated on either:

- Connell 10 (CTUs A & B)
- Connell 9 (CTUs C & D, and CTU-H locked patients)
- Kidd 10 (isolation room, preferentially CTUs A & B)
- Kidd 9 (CTU C&D)
- D5 (CTU H (20) & CTU G (8))
- C3 (CTU E (15) & CTU G (20))

Admitting does their best to bedspace patients to the appropriate ward, but depending on bed pressures, patients may be placed in a Medicine bed that is not associated with their team. A request for transfer should be made in this instance.

Both Connell 9& Connell 10 have telemetry beds available.
Peritoneal dialysis patients should be preferentially admitted to C10 because appropriately trained nurse's work on that unit, and should be admitted to Team A & B.

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Kidd 9 is shared with Hematology/Oncology ward so any active malignancies (current chemo, febrile neutropenia) or palliative patients are admitted preferentially to that unit.

Each team has their own team room (A&B on C10, C&D on C9, E team on C3, G team on D5, but often use a K10 room)

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D4ICU Unit

We have an open model Level 2 ICU (the Davies 4 ICU), where your patients may need to be to receive BiPAP, vasopressors, infusions (e.g. insulin, amiodarone), high flow oxygen/opti-flow and/or cardiac monitoring. etc. These patients remain under your care as MRP as well as the assigned CTU. These patients are typically managed by the R3, but it is important that you see the patients regularly and assist the R3 with management.

At any time if you feel that your patient requires Level 3 ICU care or critical care expertise, the ICU team must be consulted to assess the patient and consider transfer to the main ICU (located on Kidd 2, called the K2ICU)

Multidisciplinary Rounds

There are daily multidisciplinary rounds on all medicine wards, typically between 9-10am, each day Mon-Fri (Teams A&C&G at 9am / Teams B&D at 9.30am) run by the ward's charge nurse. A representative from your team should be there each day, usually the R2. The goal is a quick one-minute review of plans for each patient and identification of potential discharge date and barriers to discharge. All allied health attends as well. There are allied health rounds in the D4ICU and the R3 is expected to provide input to the nurses regarding plans for their patients.

Discharges and Patient Flow

Medicine is a busy service at KGH and to help optimize patient flow, as well as patient geographic location, patients should be ideally discharged in the morning. KGH discharge time is 10am. Any upcoming discharges that are confirmed (e.g. the following day) should be auto-discharged the day before. Specifically, the order for discharge can be written with 'dc summary to follow' if it is not yet complete. This alerts admitting to the upcoming bed. Due to COVID-19, patients cannot be placed in hallways which further limits bedmoves.

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On Call

The system

The Attending is on Primary call on a 1:5 schedule (e.g. Monday, Saturday, Thursday etc.). We have moved to a 'drip' system of call for Medicine, whereby admissions each night are divided in a 1:1 manner between teams A-D & G. Any potential short stay patients are admitted to CTU-E (assuming they do not require telemetry or D4ICU care). "Bounce-backs" go to the team that discharged them and do not count towards team numbers.

CTU-E covers consults in the ER from 0800h–1300h (1200h on weekends/holidays). Each CTU team will take Primary Call on a 1:5 schedule from 1300h – 0800h the following day but the patient admissions are split between the five main teams and CTU E (see below).

For example, if CTU-A is on call, the CTU-A senior resident takes over responsibility for managing ER consults and admissions to Medicine at 1300h, and may use members of CTU A-D & G to see consults. CTU-A would be the 'primary' team on take, but other teams will also receive admissions. The CTU-A senior resident (either R2 or R3) and the CTU-A Attending staff are in charge, but will have a combination of junior residents and medical students from CTUs A-D & G to see consults.

A typical on call night might look like the following:
CTU-A on call:

- CTU-A R2/R3 (until 10pm), Night float (IM R2/R3) takes over for 10pm-8am
- CTU-A R1
- CTU-B CC3
- CTU-C R1
- CTU-D CC3
- Extra ER (R2/R3) that will admit to G in this case. Extra ER call will admit to whatever team does not have a trainee on call that night.

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Weekends/Holidays

The weekends are similar to weekdays in that all teams will receive admissions on both Saturdays and Sundays. If your team is on call on a weekend day, your senior resident will take over the phone at 12pm (instead of 1pm). The attendings are expected to come in and round and review post-call cases each weekend day they are on service.

D4ICU Admissions

In general, sick patients admitted to the D4ICU should be reviewed by the on call attending in the afternoon/evening, but only the patients seen by the junior trainee from their team will remain under their service. You are not expected to be in hospital to review overnight D4 admissions, but may be called by the resident to review the case over the phone.

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Continuity of Care

All consults seen by the R1 or CC3/4 should be admitted to their own, respectful teams, unless the patient is E/MSSU appropriate in which case the patient can be admitted to E.

The goal is to keep patients seen by a team's junior resident or medical student with their same team (e.g. PGY1/student on B team will admit to CTU B) **this continuity of care trumps complete equality of numbers**. Post-call rounding is much more efficient if learners can present to their own team. Variations in the number of admissions between the teams will occur due to a number of factors, including: efficiency of juniors doing consults, some cases will be admitted to CTU-E, some will go to other services, some will be admitted by consult service etc.
Disputes should be resolved by the Attendings, or failing that, the CTU director.

Transfers to Medicine/Admissions from locations other than ED

Transfers out of ICU to will be assigned to a team based on what ward they are moved to. For example, if the patient is on C10 then the assigned team will be A or B. The resident at 7074 will assign the team. Bouncebacks (see bounce back policy) go to their original team regardless of their ward location.
GIM consult admissions are consults seen by the GIM consult team in clinic or Dialysis and admitted to CTU. These admissions should also go to the most appropriate team based on their ward location (as above) in order to preserve geographic consolidation as much as possible. Sometimes the GIM consult team will transfer appropriate patients from other services to CTU.

'Bounce-backs'

Patients who have recently been admitted to CTU and return for admission either through ED or from clinic for re-admission, are considered 'bounce-backs' and are automatically re-admitted to the same CTU team that discharged them. By definition, the patient is a bounce-back if they were discharged and require readmission within the same resident rotation block (not the attending's block). The residents' blocks are from the first Tuesday of the block to the last Monday of the block inclusive. These patients should be reviewed by the Attending who will be MRP, unless the patient requires urgent review for admission to D4.

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CTU-E technically does not have a bounce–back policy; if a patient was recently discharged from CTU-E returns and is no longer appropriate for CTU-E, they are admitted to one of the main teams (CTU A-D&G)

ICU bounce-backs refer to patients who were under a CTU team and then transferred to K2ICU and then come out of the ICU in the same block. These patients also go back to their original CTU teams. If the patient went straight from ED to K2ICU without being reviewed by the Attending, when they are transferred out they can go to any team.

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On-Call Attending Role

The CTU Attending on call (CTU-A in the example) is expected to come in to hospital in the evening to review consults and admissions, particularly any sicker patients, patients who can be discharged home from ER or triaged to another service (e.g. Surgery), and to offer guidance to their senior resident – who is on call until 2200 when the Night Float resident takes over. You are not expected to review patients admitted to other teams, unless they can go home that night or require D4 admission. The other teams' consults will be reviewed by the other Attendings the next morning.

The on-call Attending can admit appropriate patients to the MSSU/CTU E team overnight.

The primary senior resident hands over at 2200h to the night float resident, who manages the consults and admissions overnight until 0800h.

Post call, you meet between 0730-0800h in ED to review any further consults from overnight with the night float resident and your team. Many Attendings prefer to start this review process earlier at 0700h or 0730h, however the Attending must be there by 0800h in order to ensure the post-call residents get out by 1000h.

As the CTU Attending on call, you are responsible for assisting with any issues for all patients admitted to any CTU overnight. These are almost always dealt with by the residents (R1s cover the floors overnight, and an in house R3 covers the D4ICU and assists the R1s with any issues). However if any issues arise requiring the assistance of an Attending, they will call you for help.

Inpatient Consults

You are also responsible for any emergent overnight inpatient consults – e.g. urgent Medicine consults on patients admitted under surgery or psychiatry. The R3 on call will do these consults and review with you. Please ensure the information gets passed on to the GIM Inpatient Consult service the following morning who will take care of any follow up. Please add the patient to the GIM Consult Service list in the resident handover tool in PCS. Non-urgent consults from surgical or psychiatry services can be deferred to the day team. Transfers of care between services should be left for the day GIM consult team.

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Outside Calls

The CTU Attending on call is responsible for taking outside calls and accepting transfers to KGH from 1300h to 0800h the next morning (see page 7 for practical tips).

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CTU-E and the Medicine Short Stay Unit (MSSU)

CTU-E is different from the ward-based teams.

Attendings are on for one week at a time, and the team size is smaller with a high- turnover rate. There is one senior resident (usually an R2) and two R1s. CTU-E looks after lower acuity with no identified disposition issues, high turnover patients, and manages the Medicine Short Stay Unit (MSSU) on C3. These patients are estimated to have a hospital stay of 72 h +/- 1-2 days. If the CTU teams A-D & G are very busy it helps if the MSSU can keep some of the patients that may not be typical MSSU patients. CTU-E generally has ~15patients on their list.

The day starts in ED between 0730-0800h every morning, to review new patients from the night before. Patients who were identified overnight to be likely short stays (< 72 h) will be admitted to CTU-E under the CTU-E Attending staff's name, and will need to be reviewed (if not already done by on-call Attending who was there the prior evening). When CTU services are very busy we like the CTUE/MSSU service to be as full as possible to help off-load the other teams.

The CTU-E team also covers all new ER consults from 0800 – 1300h (1200h on weekends/holidays), to give the ward teams a chance to round. Your team of residents will see all these consults. If any can go home or are good MSSU candidates, you should review them and admit to E. Patients who are not appropriate for MSSU are reviewed by the CTU-E attending and admitted to teams A-D&G, in a drip/ 1:1 fashion, starting with the next team in order from the night shift, or if there are large discrepancies in team sizes, you can admit to the smallest team first.

However, if a complicated case comes in late in the morning who clearly requires a longer stay, it is reasonable to ask the ward attending who would be receiving the patient if they would prefer to review the case directly (rather than reviewing it yourself, billing the consult, and then having the ward attending take over the patient's care an hour later). You should usually

review sicker patients in a timely manner, and if they are going to the D4ICU, you can bill the consult and the receiving ward attending can bill the ICU day code, so both are compensated.

Likewise, occasionally the on call team will see a patient in the afternoon who is clearly identified as a potential short stay – it is reasonable for them to call you and you review directly and admit to CTU-E in that case, even though it is after 1300h.

The CTU-E team does not follow patients in the D4ICU, thus if a patient has been transferred from MSSU/C3 to D4ICU, the care will be transferred to the on-call attending for that day. Similarly, CTU-E does not admit D4ICU patients to their team.

The CTU-E Attending is responsible for taking outside calls between 0800h – 1300h each day (1200h on weekends /holidays), but there is no overnight on call responsibility. You are expected to be by 0800h both weekend mornings as you would on a weekday, but the day is generally finished by ~1300h.

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CTU / IMU H

CTU-H is our hospitalist service of ~ 30 patients.
These patients are based on D5 and C9 (locked unit).
It is run by a family physician and nurse practitioner. They care for patients who no longer have any acute medical issues, but are still awaiting a discharge destination. Most are ALC (Alternate Level of Care), awaiting a bed at some other facility – LTC (most common), Rehab, Assisted Living, etc. These patients need to be stable medically to be referred and accepted by the CTU-H Attending. An up-to-date discharge summary has to be completed by the team prior to transfer. As well, a completed and up to date GOC form must be in the chart. These patients remain under your care until the CTU-H service accepts them and writes transfer orders.

Occasionally these patients develop an acute intercurrent illness while on CTU-H. In these cases, CTU-H will consult the GIM inpatient consult service who will assess and provide advice. If the patient needs to be transferred back to an acute medical team, you may be asked to take them in transfer; with the goal being return to CTU- H once their acute medical issue has settled. If the patient has been transferred within the block from CTU A-D&G they are considered a 'bounce-back' to that team.

Designating patients as ALC

Once a patient's acute medical issues have resolved, if they are not able to be discharged directly home due to social reasons or lack of home-care supports/safety, then patient can be designated 'ALC'. (Alternate level of care)
The charge nurses on each ward are responsible for completing paperwork to reflect this change and these requests to the Charge Nurses should ideally be made in board rounds, Mon-Fri. Similarly, if a patient becomes 'acute' while they are ALC, the Charge Nurses are responsible for changing their status in PCS.
The CTU team is responsible to modifying the frequency of VS monitoring and BW orders.

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Some Practical Aspects of working at KGH

Accepting Patients from Peripheral Sites

KGH is the tertiary care centre for patients from the communities to the west of us of Cobourg, Belleville, Picton and Napanee, to the east Brockville, and as far north as Perth/Smith's Falls and Bancroft. We also have a special relationship with the aboriginal communities of James Bay, whose communities are served by a small family medicine run hospital at Weenebayko/Moose Factory, whose patients frequently require transfer down for tertiary care.

None of these sites has in-patient dialysis capacity, and we are frequently called for transfer of patients who either need acute dialysis or are chronic hemodialysis patients who require hospitalization for a variety of reasons. KGH must accept these patients, as we are the dialysis centres for the region. If patients who would otherwise be stable to be hospitalized in the periphery (e.g. Simple pneumonia, on supplemental oxygen) are on chronic hemodialysis, they still need to be transferred to KGH for inpatient dialysis during their hospitalization. Usually Nephrology is closely involved with these transfers, as they often receive the first call.

Belleville has full on site Internal Medicine 24 hours/day, Level 3 ICU, CT/MRI, basic surgical subspecialties and limited IVR, and also has medical subspecialists including cardiology, nephrology and gastroenterology. Patients usually come for a very specific tertiary care reason, but can be repatriated back at a relatively early stage once that is complete. IVR will only accept a patient for a procedure if a medicine attending agrees to be the MRP, so you may be asked to do this to facilitate a procedure for a patient who will likely not require admission to KGH. The other sites are smaller, have some daytime Medicine coverage (Napanee, Brockville, Perth/Smith's Falls) or none at all (the rest), and may have limited resources.

As the CTU Attending on call, you may receive calls from the physicians at these centres, or from community physicians around Kingston. You may be able to deal with questions over the phone, but often transfer to KGH is required. There are two ways to do this:

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1) Accept a patient from another institution directly to a bed on the wards (if currently an in-patient)
This requires completing a "HARF" (admission form) and sending it to Admitting. Admitting will notify the other facility when a bed is available and the patient will arrive. Unstable patients should not be directly admitted to the ward (they should go via the ED) unless you can secure a D4 ICU bed which is rare. If a patients has a HARF done and is waiting to be transferred you should add details to the Internal Medicine Transfer list using the resident handover tool in PCS. (see below)

2) Accept a patient from another institution to be seen, assessed and admitted via the on call team in the ER at KGH
Let the senior resident on call know, let the ER charge nurse know (may have to negotiate with them- extension 7003). Patients usually arrive quickly, and can be assessed by your team / you in ER and admitted with appropriate triage / investigations at that time. These patients come 'direct to medicine' and are not seen by the ERP.

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Internal Medicine Transfer List

If you have accepted a patient overnight and they have not arrived by the next morning, ensure the information is passed on to either the CTU-E team or the next day's on call CTU team. We also expect that all accepted transfer patients be logged on the electronic Internal Medicine transfer list. This can be found on PCS under Tools → Resident Handover→Consult List →Internal Medicine Transfers.

Subspecialists Accepting Patients / "One Call" Policy

The Department of Medicine has a "One Call" policy for accepting patients from the periphery. If a Dept. of Medicine subspecialist has been contacted first by a peripheral centre, they can (and should) accept the patient to KGH to a Medicine bed under your name as the accepting CTU Attending. It is their responsibility to inform you (and/or your senior resident) and the ER of the patient details. The subspecialist should not make the community physician make any further calls to repeat the story to a CTU Attending. This scenario occurs frequently with hemodialysis patients, and GI bleeds, as community physicians tend to call the On Call nephrologist or gastroenterologist first, but these patients would come to KGH to be assessed and admitted by Medicine, but it applies equally to any of our medical subspecialties. Also, those services would be expected to also see the patient (either same evening or next morning).

Subspecialists do directly admit some unique patients who have complex subspecialty needs. (See 'Direct Subspecialty Admissions' document)

Criticall/ ICU Transfers

You may also receive a call from Criticall about a transfer that requires ICU care, but can potentially be managed in the D4ICU rather than the K2ICU. Often the K2ICU physician is called first after hearing the story instructs Criticall to contact the Medicine Attending for admission to D4ICU. If you are unsure where the best destination is for the patient, you can always touch base directly with the ICU attending on call.

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Code Gridlock or 'Life and Limb'

These are terms used to describe a scenario where movement of patients within the institution is at a standstill, and we have some combination of excess critical care, post-operative, ward over-capacity and emergency room beds in use, with no clear possibility of decanting these patients in the next few hours. It is called by KGH Administration based on specific metrics, and can last from a few hours to a week.

Realistically, it does not affect our daily work on CTU, which should continue as usual, although with special effort to discharge patients. If there are barriers to discharge (like CCAC, difficulty repatriating patients to peripheral sites, sending patients back to NH or LTC facilities, getting consults done etc.) then there is high-level administrative pressure to fix these issues.

It does change your ability to accept patients from other centres, however. Technically, we are not allowed to accept outside patients during a Code Gridlock, however practically, we sometimes can. If called by an outside facility, you can take the information and either decline to take the patient (based on Code Gridlock, the other facility then either has to hold on to the patient pending the resolution of a Code Gridlock or Criticall the patient out to another facility), or you can try to still get the patient to KGH. This involves speaking to the ER charge nurse to see if there is space and calling the OM (7021) Sometimes for specific populations, e.g. Dialysis patients, patients from Moose Factory, and depending on the circumstances of the gridlock (e.g. over capacity critical care but ER is ok, vs. overwhelmed ER but critical care beds available), a transfer will be permitted and you can subsequently call back the sending facility to accept their patient.

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KGH Admission Algorithm

The KGH Admission Algorithm (on CTU Resources site) was developed by the Medical Program Leads in all departments to assist with directing consults and admissions in the ER. It is very helpful to us at re-directing consults that often used to come to Medicine as a default. Examples: Empyema should be seen and admitted by Thoracics, not Medicine with IVR. Post-op infections should return to their surgical service, regardless of whether further surgery is planned, and not to Medicine for antibiotics. Infected diabetic foot ulcers should be referred first to Orthopedics or Vascular Surgery, not Medicine. Failure to cope at home should be referred to SW, CCAC by the ER physician, not referred to Medicine for admission. It is definitely worth familiarizing yourself with the guidelines.

In the same vein, don't accept patients from the periphery if they have a non-Internal Medicine problem, although we often receive these calls. Example: A patient in Perth/Smith's Falls with a hip fracture on hemodialysis should be seen and admitted by Ortho with Nephrology following to arrange the dialysis. Similarly, if any patient has primarily a surgical issue, with secondary medical issues, they should be admitted to the appropriate surgical service with the GIM inpatient consult service following. On call, your team may end up seeing these patients to offer peri- operative advice, but you should not admit these patients to Medicine. Just ensure the information is handed over the next day to the GIM consult team who can continue to follow these patients on the surgical service.

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PCS Inbox

It is possible (and suggested) that you set up an Inbox in the Patient Care System to keep track of patient results. It is not automatic, and requires one phone call to IT / Help Desk to arrange.

The Inbox appears as a tab at the top left of the PCS screen after you log in. All bloodwork and imaging studies on patients admitted to you will appear here, which makes it easy to keep on top of results. The downside is that you will also find results on patients you had nothing to do with, who may have been logged in ER under you, but seen by a colleague, or admitted to another CTU. These can be ignored. We have no way currently of redirecting the results, but they ARE copied to the attending physician, if it is not you, so you should not be responsible for them.

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Electronic Handover List

In PCS there is an electronic handover list that you can use to keep track of patient problems and plans. The residents are expected to use this list for their handovers. This is especially useful when you are picking up and handing over a service. This list can be accessed in PCS by going to: Tools→ Resident Handover →Service →select your team. The list can be printed if desired.

EntryPoint

KGH has a system for writing and signing orders called EntryPoint. This system is accessed on the tabs on the left side of the opening page on PCS, using your Windows username and password. This is NOT a fully electronic Order:Entry system. It is used primarily for admission orders and order sets (e.g. IV heparin protocol, DKA order set, etc.) Entry point can be found on the left hand side of the PCS screen under Patient Shortcuts. Entrypoint electronically uploads order sets and allows you to fill out orders yourself, or sign off student orders and review resident admission orders.

Discharge Summaries

All patients leave hospital with a copy of their discharge summary. This is sent electronically to your queue under "KGH/HDH Report Verification/Signoff" or your "In-Box". You can (and should) edit these (comes up as a MS Word file). Once signed off, the e-Discharge Summary is complete and sent to the patient's family physician. E-Discharge Summaries should be edited and signed off within 72 hours of the discharge, as mandated by hospital policy.

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CTU "rules" for specific scenarios / FAQs

Caps on Team Size

CTUs A – D & G:

There are no caps for number of admissions per night. Similarly, there is no cap on team sizes.

CTU-E:

The MSSU typically has 10-15 patients, but the cap for the team is 20 patients.

Stroke Admissions

All strokes (acute code stroke or otherwise) and TIAs are seen in the ER by the Neurology service. All strokes (regardless of whether tPA was given, rehab potential, or other circumstances) should be admitted to the Neurology service and Stroke Unit on Kidd 7.

Patient who develop a stroke while on a CTU team should have a consult to the Stroke service and ideally be transferred to K7 to benefit from in-patient stroke care. Please refer to the CTU/Stroke service document for further information.

Cancer Clinic Medicine Consults

For the most part, referrals (usually for admission) from the cancer clinic should be seen in the cancer clinic by the GIM Inpatient consultation service during the day. The residents on call in the ER are not expected to go down to the cancer clinic to see a consult, and the emergency department is not supportive of these patients being transferred to the ER for assessment, unless they are unstable and need urgent assessment/intervention, in which case the oncologist usually co-ordinates a transfer to ER in conjunction with the Medicine team on call.

The GIM consultation service resident can decide based on their assessment who to discuss the case with – if the patient does not require admission, or should really be admitted to another service (e.g. acute spinal cord compression for radiation should be admitted directly to Radiation Oncology), they should review with the attending staff on GIM consults. If the patient is likely a short stay (just needs some fluid resuscitation, bloodwork etc.), they may call and review with the CTU-E attending, and have the patient admitted to CTU-E. If the patient clearly needs admission for a longer stay on the ward, the

patient should be allocated to one of the ward teams, and reviewed by the attending staff of that team. The admission paperwork and review usually would occur in the cancer clinic and the patient would be ultimately transferred to the ward when a bed becomes available. If the referral is towards the end of the day, when the cancer clinic is closing, the patient is usually transferred to ED (ER-H) just down the hall from the ER, and can be assessed by the on call team.

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Failure to cope / Frail elderly with disposition issues

Medicine is sometimes asked to see patients in the ER who essentially have failure to cope at home, without any acute medical issues. Much discussion has gone on at the Program and hospital administration level about what to do with these patients, who can no longer be cared for at home, but really have no indication for admission to an acute care facility. These patients are not well served by an admission to Medicine, as they develop many in hospital complications, and they lose their position in a queue for long term care crisis placement (hospital is considered a "safe home"). Many are stuck in hospital for many months or years, awaiting either placement or death.

If you are asked to see a patient like this in consult, see the consult to ensure no active medical conditions e.g. delirium. If you cannot identify an acute medical issue that would require admission to internal medicine, and the reason the patient cannot go home is social/family support/home care/dementia etc., then they SHOULD NOT be admitted to Medicine. The care returns to the ED physician, who co-ordinates social work, home care, long term care applications etc., and serial ED physicians (usually ED NP Danny Quann) are responsible for caring for the patient in the ED until they leave the ED.

Sometimes an ED physician will request that the Medicine Attending staff follow the patient daily, for "continuity", despite there being no active medical issues. At the program and administrative level, it has been agreed that this is NOT appropriate and should NOT happen. If you are asked to do this, you should decline, and know that you have the full support of the CTU Director and Medicine Program Director.

If you are asked to admit one of these patients to await crisis placement, kindly refuse and feel free to contact the CTU director. The Chief of Staff will sometimes request that the patient be admitted for a variety of reasons (unsafe to stay in ED for prolonged period, etc.) If these patients are admitted to hospital to offload ED, they are meant to be distributed among various services and not only admitted to medicine. Only the Chief of Staff can force you to admit the patient

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Dementia with Behavioural Problems

Patients with dementia and problematic behaviours (e.g. aggressive, sexually inappropriate, etc.) fall into a different category for admissions (compared with crisis placement). These patients are best served by a Geriatric Psychiatry service and Seniors Mental Health, whose services reside at PCH. Unfortunately, they do not accept patients directly from KGH ED and there are often long waits for admission to PCH. As well, these patients typically are too unstable/unsafe to be managed in LTC.

An algorithm was developed to guide management and admission for these patients that is available on the CTU resources page and in . The algorithm was developed by KGH ED in conjunction with PCH Mental Health, KGH Psychiatry and KGH Medicine. In summary, patients are to undergo a trial of medical management of their behaviours in ED, if they fail to improve, the vast majority are to be admitted to Psychiatry, but some may be admitted to Medicine.

If you are asked to see one of these patients in consultation, please firstly ensure there is no evidence of delirium, as delirious patients with a potentially reversible medical cause will be admitted to Medicine. If you are unsure about whether to admit to Medicine, please feel free to contact the CTU director, or COS.

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CTU Contact Information

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  - Patient disposition issues
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