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CTU Admission Structure

Admissions for Medicine CTU Teams

Call structure for CTUs A-D&G&K

- "On-Call" starts for CTU A-D teams at 4pm M-F and noon/12pm weekends/holidays
- Call continues until 8am post-call day
- The "on call" team is divided between teams on a rotating basis 1:4 (A-B-C-D-A..)
- The "Primary on-call" team will consist of
    - 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 all teams, ideally G, and help review consults with juniors.
- *All trainees should ideally 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 R1s and Clerks stay overnight.

Example	Trainees	Attending on-call
Day 1:	**CTU A** Senior / 2R1 & 2CC for teams CTU A, B, C, D / Extra ER	**CTU A**
Day 2:	**CTU B** Senior / 2R1 & 2CC for teams CTU A, B, C, D / Extra ER	**CTU B**
Day 3:	**CTU C** Senior / 2R1 & 2CC for teams CTU A, B, C, D / Extra ER	**CTU C**
Day 4:	**CTU D** Senior / 2R1 & 2CC for teams CTU A, B, C, D / Extra ER	**CTU D**

Then repeats ..

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Guidelines/ 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).
- There are no caps on number of admissions or census for CTU A-D.
- 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
- Overnight, CTU-G can take a maximum of 2 admissions, and has a cap of 16 patients, NO D4 admissions
- CTU-K has no cap on overnight admissions, can accept D4 patients, but NO holdovers. CTU-K has a cap of 20 patients

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

- CTU E has a soft **20 patient cap** , typically has a census of 15-20 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 from overnight and all new ED consults from 8am-4pm (M-F) and 8am-noon (weekends & holidays)
- Any patients deemed NOT appropriate for the MSSU are assigned to a CTU A-D&G&K 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. A CTU-E JA will often review direct with the accepting Attending.
- Transfer of care to receiving team occurs when patient goes up to the ward OR at 4pm, whichever comes first
- On-call CTU teams (A-D) 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 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 to G/K)
- Direct transfer into D4ICU should ideally go to the Primary on-call team

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CTU-G Structure

- CTU-G is an acute care medicine team that is resident-independent and typically has no trainees
- The team consists of a PA and Attending.
- The team has a cap of ~16 patients, but may expand at the discretion of the Attending
- The team will not take direct/new D4 admissions, but if their ward patient is transferred to D4, the Attending can decide if they will continue to care for the patient or transfer to another team
- Sources of admissions: as this team does not have junior members on call, the E team will preferentially admit longer stay patients to G, and Extra ER will also admit to G overnight. (max 2 admissions overnight) As well GIM consults can admit to this team, ICU transfers to C3.
- CTU-G will take 'bounce-backs' similar to other teams
- If a hospitalist is Attending on the service and require IM assistance, GIM consults can be consulted.

CTU-K Structure

- CTU-K is an acute medicine teaching team that is typically staffed by an Attending physician and 2 senior residents.
- The team has a cap of ~20 patients
- The team accepts direct D4 admissions
- NO holdovers
- Bounce backs are similar to other teams
- Home ward is C3

"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
- CTU-E is the exception and does not automatically take bounce-backs unless the subsequent presentation is suitable for MSSU
- 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

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"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
    - The Nightfloat resident may call the Attending on-call to discuss a case for direct discharge from ED overnight
- 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 24hr of admission
- 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.
- 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 the following morning
- Post-call mornings all Attendings will review patients not previously seen
- An Attending presence is expected each weekend day/holiday on service
- All residents are expected to be released for teaching (Sign-in rounds, AHD, etc) and the Attending most cover patient care during these resident absences

For a more detailed review of Queens CTU structure, please refer to the 'CTU Attending handbook'
Contact for CTU related issues/questions: Dr Kristen Marosi kfm@queensu.ca