

Handbook  
for  
Attending Staff  
on the Clinical Teaching Units (CTUs)

Kingston General Hospital

Department of Medicine Queen's University

October 2025



## Table of Contents

<b>CTU Attending Expectations.....</b>	<b>3</b>
<b>CTU Team Structure .....</b>	<b>5</b>
CTUs A – D.....	5
CTU-G.....	6
CTU-K .....	7
D4ICU Unit.....	8
Multidisciplinary Rounds .....	8
Discharges and Patient Flow.....	8
On Call .....	9
CTU-E and the Medicine Short Stay Unit (MSSU).....	15
CTU H / IMU H.....	17
<b>Some Practical Aspects of working at KGH.....</b>	<b>18</b>
Accepting Patients from Peripheral Sites.....	18
Direct Admit Process on Lumeo .....	19
How to create Medicine Pre-Admit Patient List on Lumeo account.....	20
‘Life or Limb’/Critical Occupancy .....	23
KGH Admission Algorithm .....	25
Results FYI Inbox.....	25
Provider Handoff Tool.....	27
Discharge Summaries .....	29
Creating Patient List .....	29
<b>CTU “rules” for specific scenarios / FAQs.....</b>	<b>31</b>
Caps on Team Size .....	31
Stroke Admissions .....	31
Cancer Clinic Medicine Consults.....	31
Failure to cope / Frail elderly with disposition issues .....	33
Dementia with Behavioural Problems .....	34
<b>CTU Contact Information .....</b>	<b>35</b>
<b>Useful Phone Number Extensions .....</b>	<b>35</b>



## 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. This should be completed as an addendum to the resident note on Lumeo
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 on call
  - b. Attending must be available mornings to review new admissions
  - c. Attendings must be present on the ward during Core AHD
4. Attending must be available to answer calls/pages from the nurses and address urgent issues during Core Academic Half Day (Wednesday and Thursday afternoons, usually 1:30-4:30pm)
5. 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
6. Attending to Attending handover must occur at the end of each two (or one) week block
  - a. Ideally the 'Provider Handoff' tool in Lumeo is reviewed by the attending prior to handover
7. 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
8. Attendings are expected to give verbal feedback to all trainees on the team at the end of their block as MRP.

Kingston Health  
Sciences Centre

Centre des sciences de  
la santé de Kingston



9. Attendings are expected to complete CBME forms for IM residents, both field notes and PPA forms
10. Attendings **MUST** release all post call clerks and residents by **10am at the latest** on their post call day.



## CTU Team Structure

### CTUs A – D

#### Team Structure and Location

Each of the four ward CTU teams consists of 2 senior residents (typically an IM R3 & R2), 2-3 R1s (a mix of IM and off-service residents), and 2-3 clinical clerks (medical students in their third or fourth year and occasionally an elective medical student). With a drip patient admission 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 for CTUs A-D.

Each of the CTUs A, B, C, D&K&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 CTU-G & K navigator are shared. CTU-E does not have a dedicated navigator as short stay patients typically do not have disposition issues.

The teams are mostly geographically consolidated on either:

- ❑ Connell 10 (CTUs A & B, and CTU-H locked patients)
- ❑ Connell 9 (CTUs C & D, and CTU-H locked patients)
- ❑ Kidd 10 (isolation rooms, preferentially CTUs A & B)
- ❑ Kidd 9 (CTU C&D), Neurology overflow
- ❑ D5 (CTU-H and other ALC)
- ❑ C3 (CTU E & G & K)

*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.*

Connell 3, 9&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 Teams A & B.



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&G&K on C3)

## CTU-G/Hospitalist Service

CTU- G is an acute CTU service that transitioned to 'Resident Independent'. This team functions with only 2 Attendings (hospitalist), and a PA. These are a mix of IM and FM trained physicians.

Please refer to 'CTU-G guidelines' for further information and details.

In short, because there are no house staff, this team functions differently from the other CTUs.

A few important differences are:

- Source of admissions are from CTU-E during the day, and the overnight on-call teams
- This team continues to take ICU transfers to D5/C3, direct admits and transfers by GIM consults
- Cap of ~36 patients, may be increased at Attending's discretion
- No direct D4 admissions (Attending discretion re: remaining as MRP for their own ward patients that are transferred to D4, otherwise these patients can be transferred to a main team)

This team does not take overnight call, but the Attending is responsible for rounding on the patients everyday , including weekend days. Any new admissions must also be reviewed in the morning with the overnight residents.

\*Of note, as of January 2026, the hospitalist team will cover their own patients overnight (including H patients) as home call.

As this team has no residents, the Attending is responsible for attending allied health rounds (C3 library). Attending must handover patients to on-call resident (non-take) at



5pm on weekdays, 12pm on weekends/holidays.

This team does have a Care Navigator to help with complex disposition issues.

## CTU-K

CTU-K is an acute medical teaching team that started in January 2024. This team is unique as it is structured to have an Attending and 2 senior residents. This allows the senior residents to directly care for their patients, rather than supervising junior learners.

CTU-K has a cap of 20 patients, and this can be increased at the discretion of the Attending.

CTU-K accepts direct to D4 Admissions. There is no cap on overnight admissions, but this team does not accept 'holdovers'.

There is no overnight call for this team's Attending, but weekend and holiday rounding is required. The team's residents are still on call for other reasons during the block (extra ER, D4 call, CSU call, etc)



## 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 (eg insulin, amiodarone), high flow oxygen/Airvo 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). You can reach the ICU consult team at x7227.

## Multidisciplinary Rounds

There are daily multidisciplinary rounds on all medicine wards, typically between 9-10am, each day Mon-Fri (Teams A&C at 9am / Teams B&D at 9.30am/ E, G&K at ~930/45 on C3) 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 (eg the following day) should be auto-discharged the day before. The charge nurse should be notified in board rounds of any expected discharges that day so that Admitting can be notified.





## On Call

### The system

The Attending is on Primary call on a 1: 4 schedule (e.g. Monday, Friday, Tuesday 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. Any potential short stay patients are admitted to CTU-E (assuming they do not require D4ICU care). "Bounce-backs" go to the team that discharged them. CTU G and K take admissions up to their patient cap.

CTU-E covers consults/admissions in the ER from 0800h–1600h (1200h on weekends/holidays).

Each CTU team will take Primary Call on a 1:4 schedule from 1600h – 0800h the following day but the patient admissions are split between the six 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 1600h, and may use members of CTU A-D 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 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 some patients to G as well as other teams, and help review cases with juniors.

Kingston Health  
Sciences Centre

Centre des sciences de  
la santé de Kingston



## 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. You may also be called by the D4 resident overnight for assistance with any sick patients already admitted to D4ICU.

### Continuity of Care

All consults seen by the R1 or CC3/4 should ideally be admitted to their own respective teams, unless the patient is E/MSSU appropriate in which case the patient can be admitted to E. Also admissions to G&K may divert patients from the junior's team. Ideally E admits to G&K during the day.

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 reviewing 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 K2ICU 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 (Admitting should let call them to let them know of a patient coming out of K2ICU). 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) 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.

Kingston Health  
Sciences Centre

Centre des sciences de  
la santé de Kingston



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

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.

## 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 review appropriate patients to the MSSU/CTU E team overnight (but is not required).

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 ideally be there by 0800h to ensure the post-call residents get out by 1000h. NB: Post-call rounding on already admitted patients by residents and clerks is discouraged.

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 D4 resident 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 provider handoff tool on Lumeo. Non-urgent consults

Kingston Health  
Sciences Centre

Centre des sciences de  
la santé de Kingston



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.

### Outside Calls

The CTU Attending on call is responsible for taking outside calls and accepting transfers to KGH from 1600h to 0800h the next morning (see [here](#) for practical tips).



## 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. As of July 2023, there are three senior residents and three R1s, there is also sometimes a Junior Attending (R4/5 in GIM or R4 in IM). There is a ward team and a consult team, with the idea that each team member helps the other out depending on ward and ED workload. CTU-E looks after lower acuity patients 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, K 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 ~15-20 patients on their list. CTU-E typically does not admit any direct to D4 patients but if one of their patients is transferred to D4 then the Attending can decide if the patient should be transferred to CTU A-D, K.

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'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 – 1600h (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 admitted by the other teams (A-D,G,K) in a drip 1:1 fashion, starting with the next team in order from the night shift. If there are large discrepancies in team sizes, you can admit to the smallest team first. CTU-E should preferentially admit longer stay patients to CTUs G&K during the day as this team has no residents admitting directly to them overnight. After 13h, admissions can be reviewed by the accepting CTU Attending (eg A) if they are available and if not, it is the responsibility of the E attending to review the

Kingston Health  
Sciences Centre

Centre des sciences de  
la santé de Kingston



admission.

If a complicated case comes in later in the day 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.

The CTU-E Attending is responsible for taking outside calls between 0800h – 1600h each day (1200h on weekends /holidays), but there is no overnight on call responsibility. You are expected to be present by 0800h both weekend mornings as you would on a weekday, but the day is generally finished by ~1300h.





## CTU H

CTU-H is part of the hospitalist service and manages ALC patients.

These patients are based on D5 but some are also on other units (if they require a locked unit).

It is run by a nurse practitioner as MRP with support from CTU-G Attendings. These patients 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 NP. An up-to-date discharge summary must be completed by the team prior to transfer (Hospital course in Discharge Workflow). As well, a GOC order must be updated in Lumeo. These patients remain under your care until the CTU-H service accepts them and transfers the patient to the CTU-H attending.

Occasionally these patients develop an acute intercurrent illness while on CTU-H. In these cases, at the discretion of the NP- CTU-H will consult the GIM inpatient consult service who will assess and provide advice, or the CTU-G Attending. 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, K 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).

This should be discussed with the Charge Nurse on each ward, ideally during board rounds, Mon-Fri. The order for "ALC designation" can then be placed in Lumeo.

If a patient becomes 'acute' while they are ALC, an order should be placed for "ALC discontinuation".

**The CTU team is responsible to modifying the frequency of VS monitoring and BW orders when making a patient ALC.** ALC patients are typically seen by the CTU team twice per week (barring any intercurrent illness).



## 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 to KHSC 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 inpatient dialysis centre for the region. Patients who would otherwise be stable to be hospitalized in the periphery (e.g. Simple pneumonia on supplemental oxygen) but are on chronic hemodialysis, 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:

- 1) Accept a patient from another institution directly to a bed on the wards (if currently an in-patient)

This requires completing a Direct Admit message on Lumeo ([see instructions below](#)) 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. If you have accepted a patient, you must also let the medicine senior resident in the emergency department know (x7074). You may choose to document phone advice/plan for transfer in the patient's chart on Lumeo. Sometimes these patients don't come for many days, so we don't add them to the 'tracker' in ED.

- 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 (x7074), let the ER charge nurse know (may have to negotiate with them- x 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. This is typically only possible if the patient is NOT admitted to the peripheral hospital.

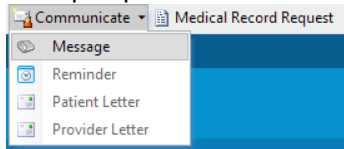
**\*\* Please ensure the patient is as stable as possible for transfer, has good IV access and any appropriate care is initiated (eg IVF, antibiotics, etc)\*\***

#### Direct Admit Process on Lumeo

When accepting a patient for transfer from an outside hospital, you must let Admitting know. This is done via Message Centre.

Steps:

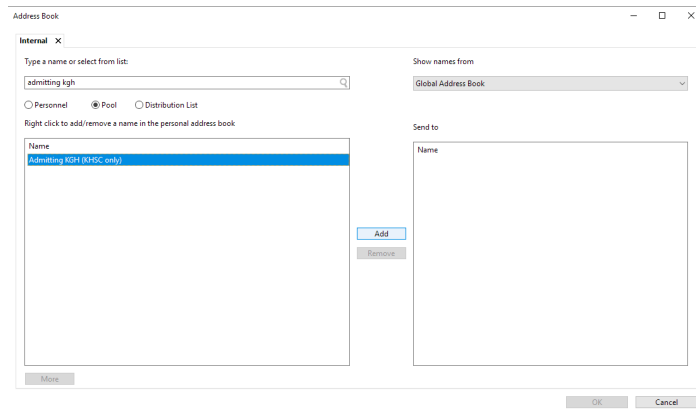
1. Open patient chart and select 'Communicate' dropdown in grey menu bar, then 'Message'



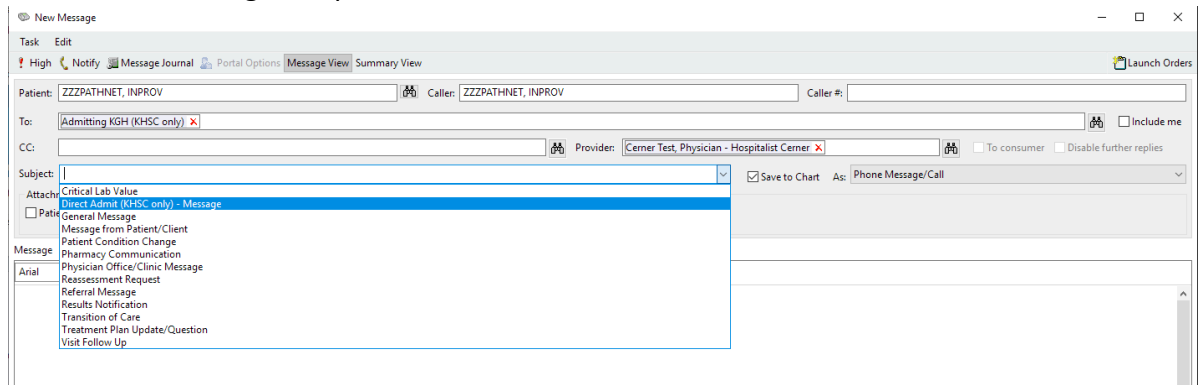
2. Complete the fields in the communication window
  - a. Beside the 'To' field, start typing 'Admitting KGH' and hit enter



- b. Select 'Pool' and choose 'Admitting KGH (KHSC only)' and select 'Add' then 'OK'. Once this appears in your 'To' field, right-click and select 'Add as Favorite' to make it easier for next time.



- c. In 'Subject' field, select 'Direct Admit (KHSC only) - Message' to populate the message template

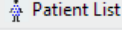


- d. Complete all details in the message (bold is required by admitting) and send
3. Admitting creates 'pre-admit encounter' and sends the FIN # back to you via message centre
4. Once pre-admit encounter created, patient should appear in Medicine Pre-Admit Patient List (see instructions below for creation)

#### How to create Medicine Pre-Admit Patient List on Lumeo account

It is helpful to create a patient list on your Lumeo account for patients who have already been accepted by medicine attendings and are awaiting transfer to KGH. You may get called by the referring physician if the patient has had a change in status or if they require updated advice.

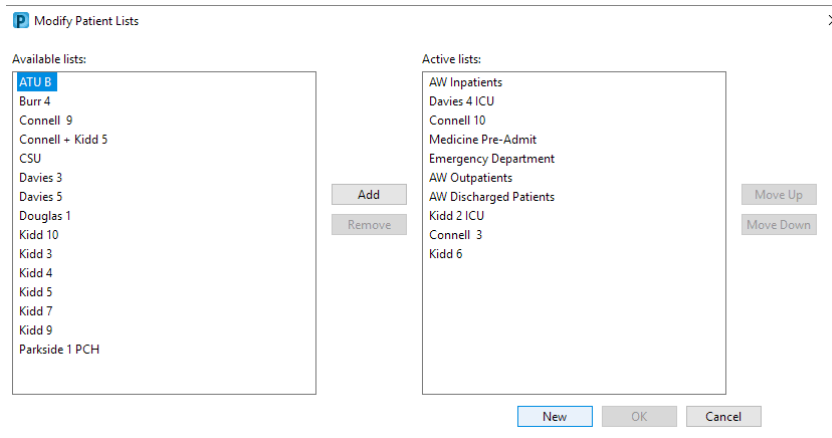
## Steps:

1. Access 'Patient List' Landing Page 
2. Select 'List Maintenance' icon in menu under Patient List heading

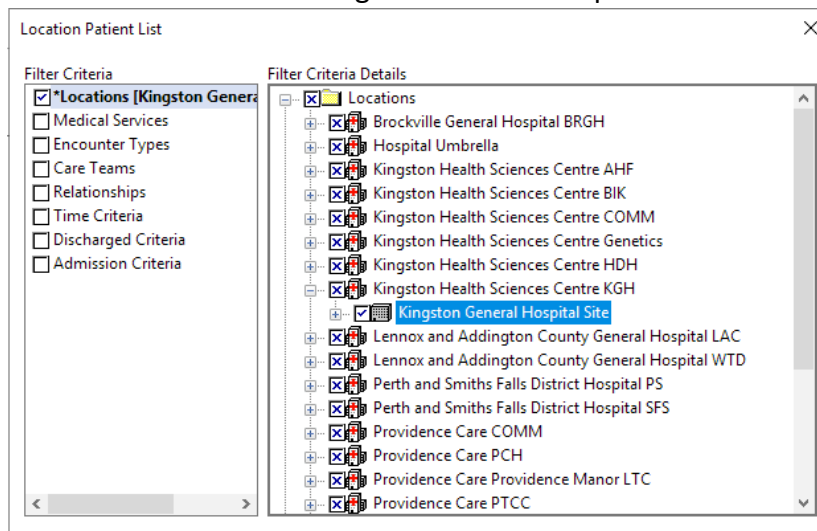
### Patient List



3. Click 'New' to make new list



4. Select 'Location' then 'Next'
5. Expand list under 'Locations' then expand list under 'Kingston Health Sciences Centre KGH'. Select 'Kingston General Hospital Site'



6. In 'Filter Criteria' select 'Medical Services' then 'Medicine' under 'Filter Criteria Details'

Location Patient List

Filter Criteria

- ☒ \*Locations [Kingston General]
- ☒ Medical Services [Medicine]
- ☐ Encounter Types
- ☐ Care Teams
- ☐ Relationships
- ☐ Time Criteria
- ☐ Discharged Criteria
- ☐ Admission Criteria

Filter Criteria Details

- ☐ Gynaecology
- ☐ Haematology
- ☐ Immunology
- ☐ Intensive Care
- ☐ Laboratory
- ☐ Long Term Care
- ☐ Long-Stay Medicine
- ☐ Long-Term Complex Medical
- ☐ Long-Term Mechanical Vent
- ☒ Medicine
- ☐ Neonatal Intensive Care
- ☐ Neonatology
- ☐ Nephrology
- ☐ Neurology
- ☐ Neurosurgery
- ☐ Newborn
- ☐ Obstetrics
- ☐ Obstetrics Antepartum

7. In 'Filter Criteria' select 'Encounter Types' then 'PreAdmit' under 'Filter Criteria Details'

Location Patient List

Filter Criteria

- ☒ \*Locations [Kingston General]
- ☒ Medical Services [Medicine]
- ☒ Encounter Types [PreAdmit]
- ☐ Care Teams
- ☐ Relationships
- ☐ Time Criteria
- ☐ Discharged Criteria
- ☐ Admission Criteria

Filter Criteria Details

- ☐ Cancelled Encounter
- ☐ Day Surgery
- ☐ Deceased
- ☐ Diagnostic Consult
- ☐ Emergency
- ☐ History
- ☐ Inpatient
- ☐ Lifetime Pharmacy
- ☐ Lockbox
- ☐ LTC Resident Inpatient
- ☐ Newborn
- ☐ Outpatient
- ☐ Outpatient in a Bed
- ☐ Outpatient Overnight
- ☒ PreAdmit
- ☐ PreRecurring
- ☐ PreReg
- ☐ Recurring

8. Enter a name for your list, and then select 'Finish'
9. This list will display all patients accepted for transfer to medicine (from outside hospitals or from home awaiting inpatient procedures)



## 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) of the patient details. If the patient is being transferred from an ED at a peripheral site to our ED, they must also let the ED charge nurse know. 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. 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)

## Critical/ ICU Transfers

You may also receive a call from Critical about a transfer that requires ICU level 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 Critical 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.

## ‘Life or Limb’/Critical Occupancy

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 many days/weeks. You should receive an email to your KHSC email account

from the Chief of Staff when 'Life or Limb' or 'Critical Occupancy' is declared (or when it is discontinued).

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 Homecare, 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 'Life or Limb' or 'Critical Occupancy', 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 'Life or Limb' status, the other facility then either has to hold on to the patient pending the resolution of the status or Critical 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 (if patient is not yet admitted to a peripheral site) and calling the Operations Manager (OM) at x7021. Sometimes for specific populations, e.g. Dialysis patients, patients from Moose Factory, and depending on the circumstances of the status (e.g. over capacity critical care but ER is ok, vs. overwhelmed ER but critical care beds available), a transfer will be permitted by the OM and you can subsequently call back the sending facility to accept their patient.





## KGH Admission Algorithm

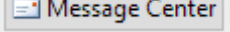
The KGH Admission Algorithm (on CTU Resources site) was developed by the Medical Program Leads in all departments to assist with directing consults and admissions in the ER. It is very helpful to us at re-directing consults that often used to come to Medicine as a default. Examples: Empyema should be 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, Ontario Health @ Home by the ER physician, not referred to Medicine for admission. It is worth familiarizing yourself with the guidelines.

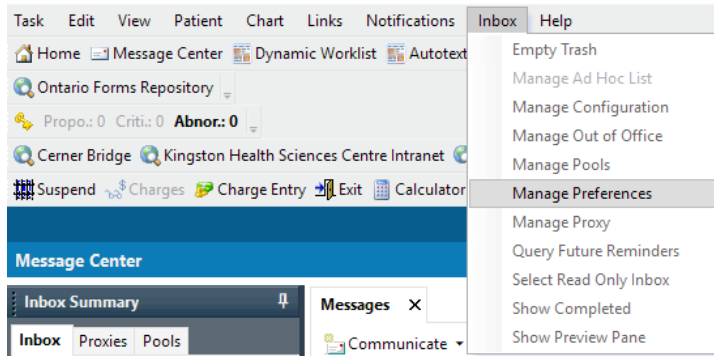
In the same vein, don't accept patients from the periphery if they have a non-Internal Medicine problem, although we often receive these calls. Example: A patient in Perth/Smith's Falls with a hip fracture on hemodialysis should be seen and admitted by Ortho with Nephrology following to arrange the dialysis. 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.

## Results FYI Inbox

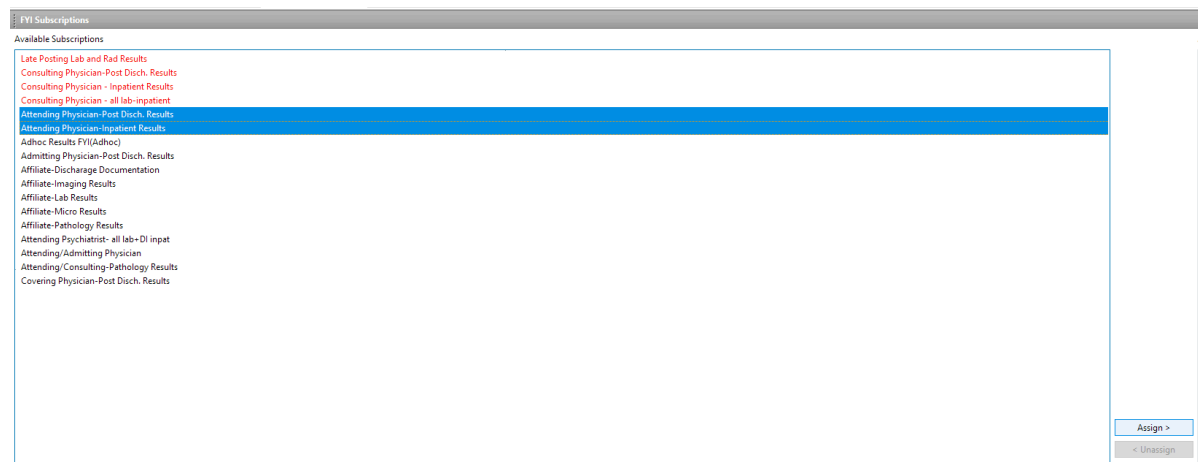
It is possible (and suggested) that you set up an Inbox in Lumeo to keep track of patient results.

Steps:

1. Select 'Message Center' landing page 
2. Select 'Inbox' in top grey menu, then 'Manage Preferences'



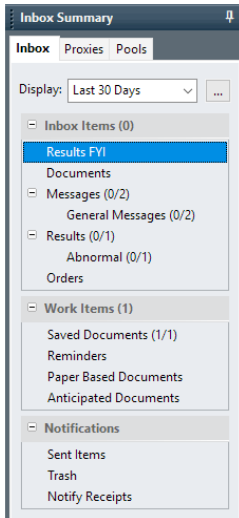
3. Select 'FYI Result Subscriptions' in pop-up window
4. Select 'Attending Physician-Inpatient Results' and 'Attending Physician-Post Disch. Results' then select 'Assign'



5. Select 'OK' to close the pop-up window
6. Patient results should now appear in the 'Results FYI' section under 'Inbox Items' in your message centre. Note that this remains a work in progress for the Lumeo team, so you may receive results for patients when you are no longer the Attending Physician.

Kingston Health  
Sciences Centre

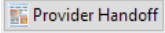
Centre des sciences de  
la santé de Kingston

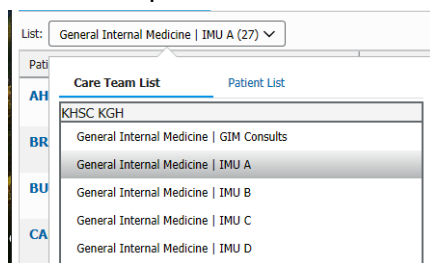


## Provider Handoff Tool

In Lumeo there is a 'Provider Handoff' tool. 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. Note that patients must be added by the residents to the care team list at the time of admission/transfer, and do not appear automatically.

Steps to access:

1. Access the 'Provider Handoff' landing page 
2. Use Drop Down beside 'List to find and select the correct IMU/CTU team



- a. If you have never accessed the Care Team List, you will need to add the correct teams. Select 'Manage Care Team Lists'

Kingston Health  
Sciences Centre

Centre des sciences de  
la santé de Kingston



Care Team List Patient List

KHSC KGH

- General Internal Medicine | GIM Consults
- General Internal Medicine | IMU A
- General Internal Medicine | IMU B
- General Internal Medicine | IMU C
- General Internal Medicine | IMU D
- General Internal Medicine | IMU E
- General Internal Medicine | IMU G
- General Internal Medicine | IMU H
- General Internal Medicine | IMU K
- Hematology & Oncology | Heme Consults
- Hematology & Oncology | Heme Ward Team
- Infectious Disease | ID consults

[Manage Care Team Lists](#)

- b. Select 'KHSC KGH' under 'Facility' and 'General Internal Medicine' under 'Medical Service', then pick IMU teams you would like to see. Then click 'Save' to apply your changes

Care Team Lists

\* Facility: KHSC KGH

\* Medical Service: General Internal Medicine

☐ Select all

☐ General Internal Medicine

☒ General Internal Medicine | GIM Consults

☒ General Internal Medicine | IMU A

☒ General Internal Medicine | IMU B

☒ General Internal Medicine | IMU C

☒ General Internal Medicine | IMU D

☒ General Internal Medicine | IMU E

☒ General Internal Medicine | IMU G

☒ General Internal Medicine | IMU H

☒ General Internal Medicine | IMU K

☐ General Internal Medicine | HELP Program

☐ General Internal Medicine | Hospitalist-1

Save Cancel

3. Click in box under 'Patient' heading, but not on patient name (as this will open the patient chart). This will reveal the handoff tool. The residents should enter a brief patient handover under 'Patient Summary' at time of admission, which can then be updated throughout the patient's course in hospital.



The screenshot shows the Lumeo Patient Handoff interface. At the top, there's a 'Provider Handoff' header. Below it, a table lists patients under 'List: General Internal Medicine | IMU B (1)'. The patient 'ZZZTEST, KHSCPHYSTRACKPREADMITA' is selected. The interface displays patient details: 23 yrs Male, DOB: 01 SEP 2001, MRN: CK200-002-695, FIN: CK2-500-004-737. It includes sections for 'Allergies' (penicillin, unable to obtain or document allergies), 'I-PASS' (Clinical Data, Care Team), 'Illness Severity' (No Severity, Unstable, Watch, Stable, Discharging), and 'Patient Summary' (23M, from home, admitted with community-acquired pneumonia). The bottom of the screen shows the user 'Cerner Test, Physician - Hospitalist Center | 13 MAR 2025 11:41' and a note about displaying information for the selected medical service only.

### Discharge Summaries

All patients should leave hospital with a printed copy of their discharge summary. This is sent electronically to your Message Centre inbox under 'Documents' once it has been completed by the resident (if they select you to 'Sign' the discharge summary). To edit it, you must open the document and then click 'Modify' symbol . You should select 'Revise Note' in the pop-up window to edit the note contents. Depending on how the resident created the note, you may not be able to edit the text directly. However, you can select all the text in the section (e.g. under Course in Hospital), then copy and paste it into the free text portion of that section. You can then edit the text. Discharge Summaries should be edited and signed off within 72 hours of the discharge, as mandated by hospital policy. Once you sign off on your note it is sent to the PCP, and you can add other consultants to 'review' the summary when you sign off.

### Creating Patient List

Before starting, it is helpful to make yourself a list on Lumeo of the inpatients currently admitted to you.

Steps:

1. Follow steps 1-5 in instructions for '[How to create Medicine Pre-Admit Patient List on Lumeo account](#)' above
2. In 'Filter Criteria' select 'Encounter Types' then 'Inpatient'

Kingston Health  
Sciences Centre

Centre des sciences de  
la santé de Kingston



Location Patient List

Filter Criteria	Filter Criteria Details
<input checked="" type="checkbox"/> *Locations [Kingston General]	<input type="checkbox"/> Cancelled Encounter
<input type="checkbox"/> Medical Services	<input type="checkbox"/> Day Surgery
<input checked="" type="checkbox"/> Encounter Types [Inpatient]	<input type="checkbox"/> Deceased
<input type="checkbox"/> Care Teams	<input type="checkbox"/> Diagnostic Consult
<input type="checkbox"/> Relationships	<input type="checkbox"/> Emergency
<input type="checkbox"/> Time Criteria	<input type="checkbox"/> History
<input type="checkbox"/> Discharged Criteria	<input checked="" type="checkbox"/> Inpatient
<input type="checkbox"/> Admission Criteria	<input type="checkbox"/> Lifetime Pharmacy
	<input type="checkbox"/> Lockbox
	<input type="checkbox"/> LTC Resident Inpatient
	<input type="checkbox"/> Newborn
	<input type="checkbox"/> Outpatient
	<input type="checkbox"/> Outpatient in a Bed
	<input type="checkbox"/> Outpatient Overnight
	<input type="checkbox"/> PreAdmit
	<input type="checkbox"/> PreRecurring
	<input type="checkbox"/> PreReg
	<input type="checkbox"/> Recurring

3. In 'Filter Criteria' select 'Relationships' then 'Visit Relationships' then 'Attending Physician'

Location Patient List

Filter Criteria	Filter Criteria Details
<input checked="" type="checkbox"/> *Locations [Kingston General]	<input type="checkbox"/> Ambulatory: Medical Assistant
<input type="checkbox"/> Medical Services	<input type="checkbox"/> Ambulatory: Patient Educator
<input checked="" type="checkbox"/> Encounter Types [Inpatient]	<input type="checkbox"/> Ambulatory: Transcriptionist
<input type="checkbox"/> Care Teams	<input type="checkbox"/> Anaesthesia Assistant
<input checked="" type="checkbox"/> Relationships [Attending Physician]	<input type="checkbox"/> Anaesthesiologist
<input type="checkbox"/> Time Criteria	<input type="checkbox"/> Appeals
<input type="checkbox"/> Discharged Criteria	<input type="checkbox"/> Appeals Analyst
<input type="checkbox"/> Admission Criteria	<input type="checkbox"/> Appeals Manager
	<input type="checkbox"/> Assigned
	<input type="checkbox"/> Assigned Care Manager
	<input type="checkbox"/> Assigned Patient to Provider
	<input type="checkbox"/> Athletic Trainer
	<input checked="" type="checkbox"/> Attending Physician
	<input type="checkbox"/> Attending Psychiatrist
	<input type="checkbox"/> Audiologist
	<input type="checkbox"/> Audiologist Tech
	<input type="checkbox"/> Behavioural Therapist
	<input type="checkbox"/> Behavioural Therapy Student

4. In 'Filter Criteria' select 'Discharged Criteria' then 'Only display patients that have not been discharged'

Location Patient List

Filter Criteria	Filter Criteria Details
<input checked="" type="checkbox"/> *Locations [Kingston General]	<input type="radio"/> None
<input type="checkbox"/> Medical Services	<input checked="" type="radio"/> Only display patients that have not been discharged.
<input checked="" type="checkbox"/> Encounter Types [Inpatient]	<input type="radio"/> Only display patients that have been discharged within the last:
<input type="checkbox"/> Care Teams	Duration: <input type="text"/> Duration Unit: <input type="text"/>
<input checked="" type="checkbox"/> Relationships [Attending Physician]	
<input type="checkbox"/> Time Criteria	
<input checked="" type="checkbox"/> Discharged Criteria [Not discharged]	
<input type="checkbox"/> Admission Criteria	

5. Name your list then select 'Finish'



## **CTU “rules” for specific scenarios / FAQs**

### Caps on Team Size

CTUs A – D

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

CTU-G: Cap of ~36 patients

CTU-K: Cap of ~20 patients

CTU-E: The MSSU typically has 15-20 patients, cap ~20 patients.

CTU-H: ~25 currently, to be increased Nov '25

### 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.

Patients 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 or Neurosx), 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

Kingston Health  
Sciences Centre

Centre des sciences de  
la santé de Kingston



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.





## 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. CTU is an acute internal medicine teaching service and so not an appropriate use of this service.

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, TCU, PTCC 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. You will need to discuss with the ED physician for this to occur.

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 placement, kindly refuse and feel free to contact the CTU director. Sometimes if all options are exhausted, the Chief of Staff (COS) will request that the patient be admitted for a variety of reasons (unsafe to stay in ED for prolonged period, etc) If admitted, the patient is made 'ALC' and IMU-H is consulted. Since COVID, once admitted patients retain their 'crisis-level' status for LTC.



## Dementia with Behavioural Problems

Patients with dementia and problematic behaviours (eg 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 ED algorithm was developed to guide management and admission for these patients that is available on the CTU resources page. 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.



## CTU Contact Information

- CTU Director: Kristen Marosi [kfm@queensu.ca](mailto:kfm@queensu.ca)
  - For Attending scheduling issues
  - Patient disposition issues
  - General inquiries
- Queen's Core Internal Medicine Residency Program Director: Stephen Gauthier [sg54@queensu.ca](mailto:sg54@queensu.ca)
  - Resident concerns
- Program Medical Director: Chris Smith [cas12@queensu.ca](mailto:cas12@queensu.ca)
- Program Operational Director: [sarah.dacosta@kingstonhsc.ca](mailto:sarah.dacosta@kingstonhsc.ca)

## Useful Phone Number Extensions

- Admitting: 1223
- Davies 4 Charge Nurse: 7150
- ER Charge Nurse: 7003
- ICU consult phone: 7227
- Operations Manager: 7021
- Senior Medicine Resident in ED: 7074