Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Queen's University

Disposition Cheat-Sheet for CTU

Your role at bullet rounds is to provide a brief medical update and an EDD (expected discharge date). Once the patient is medically stable, the allied health team and care navigators are responsible for determining what services are required for a safe transition home, or if an alternative disposition is more appropriate.

Below is a general outline of the disposition options:

Disposition	Description	Comments
PCH-rehab (MSK, Geriatrics, Stroke)	Providence Care Hospital in Kingston	Generally good for patients with cognitive issues as well as rehab goals. Accepts dialysis patients (not PD patients) Must have destination prior to application (ie RH or home, NOT waiting for LTC)
PCH-PCU	Palliative care unit at Providence Care Hospital	PPS 20-30%, life expectancy <3months Must consult KGH Palliative consult team for assessment
PCH-Hospice	Hospice run by Providence care, but located at a separate site	Generally shorter prognosis than PCU, no IVs, access to BW or imaging (unlike PCU) Must consult KGH Palliative consult team for assessment
PCH-CCC	Complex continuing care unit at Providence Care Hospital	For patients with high care needs that are chronic and needs cannot be met in nursing/LTC homes. Long wait typically
PCH-PTCC	PCH transitional/restorative care, located at St Mary's site	Run by PCH, focus is restorative care, less intense rehab
TCU	Transitional care unit, housed in the Windsor Retirement home in Kingston. Government funded. Max 60day stay. Some isolation restrictions (eg MRSA)	Different programs exist at TCU: 1. Rehab- less PT than PCH, less support if cognitive issues. Good for convalescence 2. LTC- awaiting LTC bed 3. Palliative- PPS too high for PCU
KHSC at home	KGH program for 16weeks of home care services. Services provided by Bayshore (not through LHIN/CCAC)	Must have some rehab goals, assist x1
Home 1st	Program through local homecare to provide services while patients wait for LTC, typically max 8hrs/day	Patients must wait for LTC beds at home. Only a small subset whose needs cannot be met in the community wait in hospital for LTC bed if approved by management
BTSU	Behavioural transition support unit- in Belleville	For patients with aggression and behaviours that cannot be managed in LTC homes, and cannot be stabilized after stay in hospital.
LTC homes (returning to)	LTC homes provide 24 hour nursing care and are subsidized by government funding for lower income patients.	Can support palliative patients, foley care, Titrating or new home oxygen, IV antibiotics (with at least 24 hrs notice and a OMS script)
Retirement Homes	Private pay care homes which offer different level of services such as meals and medication administration	Could delay discharge if patient unable to return home to wait for a RH bed. Can access home care services in a RH setting (IV antibiotics/wound care/PSW support)
Repatriation	Home area hospital for ongoing medical management or working towards rehab/disposition goals. To consider when tertiary care needs resolved and/or are stable Not able to support PD or HD patients.	Write an order to Repat once bed available. There is a bed wait list called by admitting daily. May take days or weeks (so keep working towards discharge), Call report promptly once bed available as may lose bed if there is a delay in giving handover to receiving physician.