# Disposition Cheat-Sheet for R2s on CTU

*Your role at bullet rounds is to provide a 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 | Providence care hospital in Kingston | Generally good for patients with cognitive issues as well as rehab goals. Accepts dialysis patients |
| PCH-PCU | Palliative care unit / Hospice housed in PCH | PPS 20-30%, life expectancy <3months<br>Must consult KGH Palliative team for assessment |
| PCH-CCC | Complex continuing care | For patients with high care needs that are chronic and cannot be met in nursing homes. Long wait typically |
| PCH-PTCC | Providence care transitional care centre at St Mary's site | Rehab and 're-activation'. Goal is more patients to be able to return home, need discharge destination post. Max 90 day stay. MD on site |
| TCU | Transitional care unit, housed in the Windsor Retirement home in Kingston. Government funded. Max 60day stay. No dialysis, no MRSA+ | Different programs exist at TCU:<br>1. Rehab- less PT than PCH, less support if cognitive issues. Good for convalescence<br>2. LTC- awaiting LTC bed<br>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 be in Kingston area. 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 NH beds at home. Only a small subset whose needs cannot be met in the community wait in hospital for NH bed |
| BTSU | Behavioural transition support unit- in Belleville | For patients with aggressions and behaviours that cannot be managed in nursing homes, and cannot be stabilized after stay in hospital. |
| Repatriation | Any patient who is from another hospital catchment area (eg Brockville, Napanee, Belleville) should return to their home hospital for ongoing care, rehab, palliation, etc as long as their care needs can be met at their home hospital | NB: Dialysis patients must remain at KGH.<br>If there are care needs that cannot be met at their community hospital, eg ongoing radiation, access to IVR, specific specialists then they stay at KGH until these are completed<br>Cannot make patient ALC awaiting repat. |

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