Kingston General Hospital
Outstanding care, always

# Kingston General Hospital Emergency Department Consultation and Admission Algorithm

## General Principles:

1. The Emergency physician will decide on which service to consult and indicate whether the consultation is for opinion only or to assume care.

2. Resident staff are expected to attend the patient and make decisions on disposition as quickly as possible in order to maintain stretcher availability and ED patient flow. Whenever possible the outcome of the consultation should be communicated to the referring physician.

3. Patients returning within 4 weeks of discharge will be the responsibility of the discharging service for admission, unless it is in the best interests of the patient to do otherwise, e.g. acute MI after hospitalization for abdominal pain by General Surgery.

4. Patients followed by a consultant on a regular basis with a presenting illness related to that specialty should be discussed with that consultant or service. Patients followed by a consultant with an unrelated presenting diagnosis will be referred to the appropriate other service.

5. If after assessment, the consulted service establishes a different diagnosis that is more appropriate for admission under another service, the patient will be referred to an alternative service for admission by the originally consulted service. The Emergency Physician should be notified of all "second consults" in the ED. At all times the patient must have a "Most Responsible Physician" assigned to their care.

6. After consultation is complete the patient will not normally be handed back to the Emergency Physician for further treatment, disposition or subsequent consultation. Exceptions must be discussed by the attending consultant and the attending Emergency Physician.

7. Attending physicians are responsible for resolving disagreements related to these guidelines. Unresolved disputes will be adjudicated by the Chief of Staff/VP Medical Administration.



Revised November 8, 2016

| CLINICAL PRESENTATION | QUALIFIED AS FOLLOWS | CONSULT SERVICE |
|---|---|---|
| **Abdominal Pain NYD** | Presentation with acute, severe pain and need admission | **General Surgery** |
| **Aortic Dissection** | All | **Cardiology: Secondary consult to be decided:**<br>• **Cardiac Surgery (Type A)**<br>• **Vascular Surgery (Type B)** |
| **Behavioural problem** | In setting of dementia, developmental disability or acquired brain injury | **Psychiatry** |
| **Biliary Tree Disease (i.e. obstruction)** | With gallbladder in situ<br>Without gallbladder in situ | **General Surgery**<br>**Internal Medicine** |
| **Bowel Obstruction** | Mechanical bowel obstruction | **General Surgery** |
| **Chest Pain** | If objective evidence or suspicion of ischemia | **Cardiology** |
| | All others | **Internal Medicine** |
| **Congestive Heart Failure** | Associated with ongoing ischemia or complex rhythm disturbance, valvular abnormality requiring urgent investigation and potential surgical intervention | **Cardiology** |
| | Followed in Heart Failure Clinic | **Cardiology** |
| | All others | **Internal Medicine** |
| **COPD/Asthma** | Requiring mechanical ventilation or noninvasive ventilator support | **Critical Care** |
| | All others | **Internal Medicine (Secondary consultation to Respirology if followed by that service)** |
| **Crisis Placement** | No medical, surgical or psychiatric need for admission | **Consultation to specific service as appropriate, care to remain under ED physician with daily assessment by nurse practitioner, social work and CCAC** |
| **Critically Ill Patients** | Intubated patients, patients receiving noninvasive ventilation, patients in need of invasive monitoring, vasopressors or seriously ill patients at high risk for decompensation | **Critical Care** |
| **Delirium** | Admission by Internal Medicine, Psychiatry may provide consultation regarding behavioural management | **Internal Medicine** |
| **Dialysis Patient** | Acute renal failure or overdose requiring urgent dialysis.<br>Access problem | **Nephrology with discussion with Internal Medicine** |
| **Diverticulitis** | All | **General Surgery** |
| **Dysvascular Limb or Diabetic foot ulcer/infection** | Patients known and actively followed by Vascular presenting with a vascular problem | **Vascular Surgery** |
| | Patients presenting with an ischemic leg and either infection, pain or gangrene and no pulses | **Vascular Surgery** |
| | Patients presenting with only infection and palpable pulses | **Internal Medicine** |
| | Patients presenting with ulceration and palpable pulses | **Orthopedics** |
| **Empyema** | Proven/suspected | **Respirology +/- discussion with Thoracic** |

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| | | **Surgery** |
| **Epidural Abscess** | All (Discitis is non-surgical and goes to IM) | **Assessed first by Neurosurgery; if non-surgical, secondary consult to Internal Medicine** |
| **Fractures – Pelvis and limb** | Surgery needed | **Orthopedics** |
| | Continuing medical problem that would require admission on its own right | **Internal Medicine** |
| | Pelvic ring (See Pelvic Fracture CCP) | **Orthopedics** |
| **Fractures – ribs** | All | **Thoracic Surgery** |
| **GI Bleed (Upper)** | Stable | **Internal Medicine** |
| | Unstable | **Gastroenterology and Internal Medicine at same time** |
| GI Bleed (Lower) | Stable | **Internal Medicine** |
| | Unstable | **Gastroenterology and Internal Medicine at same time** |
| **Head Trauma (isolated injury)** | | **Neurosurgery** |
| **Hemoptysis (massive)** | | **Respirology, unless known to Thoracic Surgery** |
| **Inability to ambulate and unable to be discharged after fall** | Patients with operable injury | **Orthopedic Surgery** |
| | If non-operable injury ED Physician decides reason for fall then: | |
| | Patients with non-operable injury:<br>- Medical reason for fall and secondary injury | **Appropriate medical service** |
| | - Trip/trauma reason for fall/secondary injury | **Orthopedic Surgery** |
| **Intracranial Hemorrhage** | If operable or potentially operable lesion | **Neurosurgery** |
| | If non-operable lesion<br>- Intubated | **Critical Care Medicine** |
| | - Non-intubated | **Neurology** |
| **Lung abscess** | All, unless known to Thoracic Surgery | **Respirology/Internal Medicine** |
| **Oncologic Problem (including complications of therapy)** | All with the exceptions below | **Internal Medicine with secondary consult to Medical or Radiation Oncology** |
| | Spinal cord compression from mass | **Spine Call +/- secondary consult to Radiation Oncology** |
| | Primary or solitary Metastatic brain tumour | **Neurosurgery (refer to Oncology/IM with multiple metastasis)** |
| **Palliative Patient** | Followed by Palliative Care Medicine (weekdays 800-1700) | **Palliative Care** |
| | Not followed by Palliative Care | **Internal Medicine** |
| **Pancreatitis** | Gallstone related | **General Surgery** |
| | All others | **Internal Medicine** |
| **Pediatric FB aspiration** | | **Otolaryngology +/- Pediatrics** |
| **Post procedure complication/problem** | All | **Service that performed procedure** |
| **Pulmonary Embolus** | If intubated/needs invasive monitoring, vasopressors | **Critical Care** |
| | Not intubated, but needs admission | **Internal Medicine** |
| **Pyelonephritis** | In setting of obstruction requiring urgent surgical intervention | **Urology** |
| | All others | **Internal Medicine** |
| **Renal Failure (Acute)** | Obstructive cause | **Urology** |
| | Medical Cause | **Internal Medicine** |
| **Seizures** | All | **Neurology** |
| **Septic Joint** | All | **Orthopedics** |

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| **Sickle Cell Crisis** | | **Hematology/IM** |
| **Soft tissue injuries or infections potentially needing surgery (i.e. necrotizing fasciitis)** | Below wrist | **Hand Surgery** |
| | Below hip/shoulder | **Orthopedics General** |
| | Trunk | **Surgery** |
| **Spinal injuries** | Cervical spine | **Neurosurgery** |
| | Thoracic/Lumbar Spine or simple T/L spine compression # for pain management | **Spine Call** |
| | Cauda Equina syndrome | **Spine Call** |
| **Stroke Syndromes** | Acute Stroke Protocol | **Neurology/Stroke team** |
| | Outside window of Acute Stroke Protocol | **Neurology** |
| | High risk TIA (see CCP) | **Neurology/Vascular Surgery as per protocol** |
| **Subdural or subarachnoid hemorrhage** | All | **Neurosurgery** |
| **Syncope NYD/presumed cardiac origin** | All | **Cardiology** |