Queen's University | Core Internal Medicine Residency Program

Hospitalist Admission Guidelines

Updated June 19, 2026

Purpose

To support our Senior Medicine Residents with patient allocation between our Hospitalist service and resident- staffed Internal Medicine Units (IMU A, B, C, D, E, K). The guiding principles of this document are:

- Both Hospitalist services and IMUs provide high-quality generalist care
- Patients on both services may still have acute medical problems requiring diligent care
- It is important to preserve the educational experience and continuity of care for trainees on IMUs
- These are not meant to be rigid rules and flexibility is expected based on system pressures, including continuity of care for overnight residents and capacity on both services

Admission Framework

Hospitalist-1, Hospitalist-2	IMU A, B, C, D, K
Reasonably stable • Ward-appropriate – no predictable concern for progression to D4 or K2-ICU level care • Support needs are minimal (i.e., ≤3L O_2 NP), stable, and not escalating • Patient with q8h, q12h, or daily vital frequency • Patients requiring a "normal" frequency of laboratory investigations (i.e., daily)	**Higher risk of clinical deterioration** • Patients admitted to D4-ICU • Patients admitted to the ward who have some predictable risk of clinical deterioration and require closer monitoring or frequent re-assessment • Patients requiring any vital frequency • Patients requiring laboratory investigations more frequently than daily (i.e., q4h, q6h, q12h)
Single-system dominant problem • Predictable clinical course and limited diagnostic uncertainty • Specialty consult may occur, but overall plan remains generalist-led. Avoid admissions that may require ≥2 subspecialty consultations	**Multiple problems or diagnostic uncertainty** • Complex differential diagnosis with need for team-based discussion and diagnostic reframing • Multi-system disease that is likely to require intensive coordination across care teams
Low procedural likelihood • Unlikely to require bedside procedures that would otherwise be preferred on IMU teams	**Procedures possible or expected** • Anticipation of procedures aligned with resident EPA and learning objectives

Frequently Asked Questions and Additional Considerations

When should Hospitalist admissions occur?

- Admissions to the Hospitalist service should be prioritized during the daytime. This allows overnight residents to primarily admit to their own team.
- Admissions after 3pm will be 'held' on CTU-E until the following morning
- Bouncebacks to hospitalist service are similar to CTU services, provided that the patient is clinically appropriate for hospitalist team. This includes when H1&H2 are at cap. *(within reason)*

What is the appropriate disposition for a patient felt to have some risk of clinical deterioration?

- Admitting patients with higher acuity to Hospitalist teams should be considered cautiously to reduce the likelihood of (1) the Hospitalist needing to come in overnight, and (2) the D4-ICU resident needing to intervene in a Code 99 situation for a Hospitalist patient
- Hospitalist staff reserve the right to decline an overnight admission if they feel the patient's need are too acute for their service (i.e., high risk of clinical deterioration, multiple problems or diagnostic uncertainty, procedures possible/expected)