Kingston General Hospital Emergency Department Consultation and Admission Algorithm

General Principles:

1. The Emergency physician will decide on which service to consult and verbally communicate the rationale for consultation to the appropriate service.

2. Consulting services are expected to assess patients within a target of 3 hours and provide a documented disposition within 6 hours to support stretcher availability and ED patient flow.

   These timeframes are goal-oriented and dependent on ED capacity. When the ED is in overcapacity, timely consultation and disposition are critical to maintain safe operations and accommodate incoming patients. When capacity allows, clinical discretion may be applied while ensuring ongoing safe patient care.

3. Patients returning within 4 weeks of discharge will be assessed by the ERP, and assuming consultation is required, would be the responsibility of the discharging service for admission, unless it is in the best interest of the patient to do otherwise (e.g. acute MI after hospitalization for orthopedic procedure). Patients previously discharged from a Level 2/3 ICU admission will be assessed by the ERP and directed to the most appropriate service (ICU if ICU-level care remains necessary, or the service most responsible for management of the presenting problem).

4. Stable patients presenting to the ED within 2 weeks of an operation/procedure and with a postoperative concern (e.g. incision site infection or postoperative pain/bleeding) will be consulted directly to the surgical/procedural service and not be seen by an ERP. For services without resident or fellow coverage, these stable consults will be held between the hours of 2200 and 0600 (insert link to post-op pathway). For unstable patients, the ERP will assess and resuscitate as required.

5. Patients returning within 48hours after discharge will be consulted directly to the discharging service and not seen by an ERP. Exceptions should be made if the presenting complaint obviously requires a different service or if the patient is acutely unwell/requiring resuscitation.

6. After consultation is complete, the patient will not normally be handed back to the Emergency Physician for further treatment, disposition or subsequent

consultation. 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. Discretion can be used in these cases, although ‘one-way consults’ are an established best practice to support ED patient flow, if the ERP is the physician most familiar with the case, they can be asked to assist with the second consult. At all times the patient must have a "Most Responsible Physician" assigned to their care.

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.

CLINICAL PRESENTATION	QUALIFIED AS FOLLOWS	CONSULT SERVICE
Abdominal Pain NYD	Presentation with acute, severe pain and requires admission	**General Surgery**
Aortic Dissection	Type A Type B	**Cardiac Surgery** **Primary consult to Vascular Surgery, with secondary consult to Cardiology if non-operative**
Behavioural problem	In setting of dementia, developmental disability or acquired brain injury	**Psychiatry (link to BPSD algorithm)**
Biliary Tree Disease (i.e. obstruction)	Gallbladder in situ Without Gallbladder in situ	**General Surgery** **Internal Medicine**
Bowel Obstruction	Mechanical bowel obstruction Ileus	**General Surgery** **Primary consult to General Surgery, with secondary consult to Internal Medicine if underlying medical cause for obstruction**
Chest Pain	If objective evidence or suspicion of Ischemia All others	**Cardiology** **Internal Medicine**
Congestive Heart Failure	1. Heart failure exacerbation associated with ongoing ischemia, unstable arrhythmia or valvular abnormality requiring urgent in-patient investigation in patients who are candidates for surgical/procedural interventions. 2. Heart failure re-admission within 30 days of discharge from cardiology. 3. New onset heart failure in patients <65yo All others	**Cardiology** **Internal Medicine**
COPD/Asthma	Requiring mechanical ventilation All others, including NIPPV	**Critical Care** **Internal Medicine**

Crisis Placement	No acute medical, surgical or psychiatric need for admission, but is unable to return to previous living arrangement.	**ED homecare team will assess with the goal of avoiding a hospital admission and, if necessary, escalate according to the "ED Admission Avoidance Pathway" (insert link)**
Delirium	All	**Internal Medicine** (Psychiatry may provide consultation regarding behavioural management)
Dialysis -acute need eg. overdose	Overdose requiring urgent dialysis	**Co consults to Nephrology and Internal Medicine**
Diverticulitis	All	**General Surgery**
Dysvascular Limb or Diabetic foot ulcer/infection	Patients who are actively followed by Vascular Surgery presenting with a vascular problem	**Vascular Surgery**
	Patients presenting with an ischemic leg and either infection/gangrene, pain and no pulses	**Vascular Surgery**
	Patients presenting with infection and palpable pulses	**Internal Medicine**
	Patients presenting with ulceration or evidence of osteomyelitis and palpable pulses	**Orthopedics**
Empyema/lung abscess	Proven/suspected Patient meets criteria for VATS, or known to thoracic surgery	**Respirology/Internal Medicine** **Thoracic surgery**

Epidural Abscess	All Discitis/osteomyelitis	**Primary consult to Neurosurgery. If deemed non-surgical, secondary consult to Internal Medicine** **Internal Medicine**
Fournier's Gangrene	Genital predominant Thigh compartment predominant	**Urology** **Orthopedics**

	Perineal predominant	**General surgery**
Fractures- Pelvis and limb	Surgery needed	**Orthopedics**
	Medical issue that would require admission in its own right and non-operable fracture.	**Internal Medicine**
	Pelvic ring (insert link to Pelvic Fracture Pathway).	**Orthopedics**
Fractures - ribs	In the setting of major trauma or with complications requiring intervention (pneumothorax, hemothorax, flail chest) In the setting of low velocity trauma (i.e. fall from standing) and no associated complications that require intervention	**Thoracic Surgery** **Internal Medicine**
GI Bleed (Upper and lower)	Stable	**Internal Medicine**
	Unstable	**Primary consult to Gastroenterology and secondary consult to Internal Medicine or ICU**
Head Trauma	Isolated injury and requiring admission	**Neurosurgery**
Hemoptysis	Massive/requiring admission	**Primary consult to Respirology, with secondary consult to Internal Medicine or ICU**
Intracranial Hemorrhage	Traumatic Intracranial hemorrhage or any SDH or large SAH Non-traumatic Intracranial hemorrhage	**Neurosurgery** **Stroke team**
Oncologic Problem (Including complications of therapy) (see link to subspecialty document)	All, with the exceptions below	**Primary consult to Internal Medicine with secondary consult to Medical or Radiation Oncology**
	Spinal cord compression from mass	**Neurosurgery with secondary consult to Radiation Oncology**
	Primary or solitary metastatic brain tumour Multiple brain metastasis	**Neurosurgery** **Oncology/Internal Medicine**

Palliative Patient	Primary indication for admission is symptom management in the setting of a life-threatening illness, OR patient who is actively dying and for comfort care only. All others	**Palliative Care** **Internal Medicine**
Pancreatitis	Gallstone related All others (including choledocholithiasis with no gallbladder)	**General Surgery** **Internal Medicine**
Pediatric FB aspiration		**Separate call roster on switchboard (shared by Otolaryngology, pediatric GI, pediatric General Surgery)**
Post procedure complication/problem	Within 14 days and stable vital signs All others (assuming admission is required)	**Direct consult to procedural service from triage (see postoperative pathway link)** **Procedural service after ERP assessment**
Pulmonary Embolus	All (unless intubated)	**Internal Medicine** (consider PERT consult as well)
Pyelonephritis	In setting of acute obstruction requiring urgent surgical or procedural (e.g. IVR) intervention All others	**Urology** **Internal Medicine**
Renal Failure (Acute)	Acute obstructive cause requiring intervention (including IVR procedure) All others	**Urology** **Internal Medicine**
Seizures	First seizure, unclear cause, or known epilepsy ETOH withdrawal or metabolic cause	**Neurology** **Internal Medicine**
Septic Joint	All	**Orthopedics**

Sickle Cell Crisis	All	**Internal Medicine with secondary consult to hematology**
Soft tissue injuries or infections potentially needing surgery (i.e. necrotizing fasciitis)	Distal to wrist Below hip/shoulder Torso	**Plastic surgery** **Orthopedics** **General surgery**
Spinal Injuries/lesions	Cervical spine, intradural lesions or Cauda Equina syndrome	**Neurosurgery**

	All other SimpleT/L compression fractures for pain management (ie. non-operative and admission is required)	**Orthopedics** **Primary consult to orthopedics with secondary consult to Internal Medicine**
Stroke Syndromes	Acute Stroke	**Stroke team**
	High risk TIA	**Stroke team or Vascular Surgery as per protocol (link to TIA pathway)**
Syncope	Presumed cardiac cause Primary medical cause	**Cardiology** **Internal Medicine**
Vertigo (work ongoing)	Central Peripheral	**Stroke** **Not yet clarified**

Appendices

1. postop pathway
2. Subspecialty Medicine Admissions
3. Pelvic fracture pathway
4. Behavioural and psychological symptoms of dementia pathway
5. TIA pathway