Emergency Department Consultation Guidelines

Revised Feb 2024

Emergency Department Consultation

Guidelines

This document will determine the most appropriate consultation service for certain presenting complaints and diagnoses as endorsed by the Medical Advisory Committee, St. Michael's Hospital.

1. Expected response times for consultations in the ED:

   To answer page:

   For STAT page (designated by "99" prior to extension): **< 5 minutes**

   For all other pages: **< 15 minutes**

   To arrive in ED and begin assessment of patient:

   Resuscitation/emergent patients: **<15 minutes**

   Urgent patients: **<30 minutes**

   Routine Consult: **<60 minutes**

   - The acuity category of the patient will be defined by the Emergency Physician, based upon the Canadian Triage and Assessment Scale. The consultant will be advised as to the required response time when the referral is given.

   - It is the responsibility of the entire service, including the responsible staff physician(s), to ensure that these response times are met.

   - It is expected that the above acuity-based response times are achieved 98%, 95%, and 90% of the time respectively.

2. A disposition decision (admission or discharge) will be made by the consulting service within 2 hours of the time of consultation.

   - It is expected that these decision times will be achieved 90% of the time.

3. The patient will initially be assessed by a member of the consulting team senior enough to make an expedited admission/discharge decision.

4. When the staff Emergency Physician anticipates that admission will be required, the admitting department will be notified by the ED in consultation with the senior consulting resident. The admission order may be cancelled or changed upon further assessment (e.g., to a different admitting service).

5. Once the decision to admit has been confirmed by the consulting service:

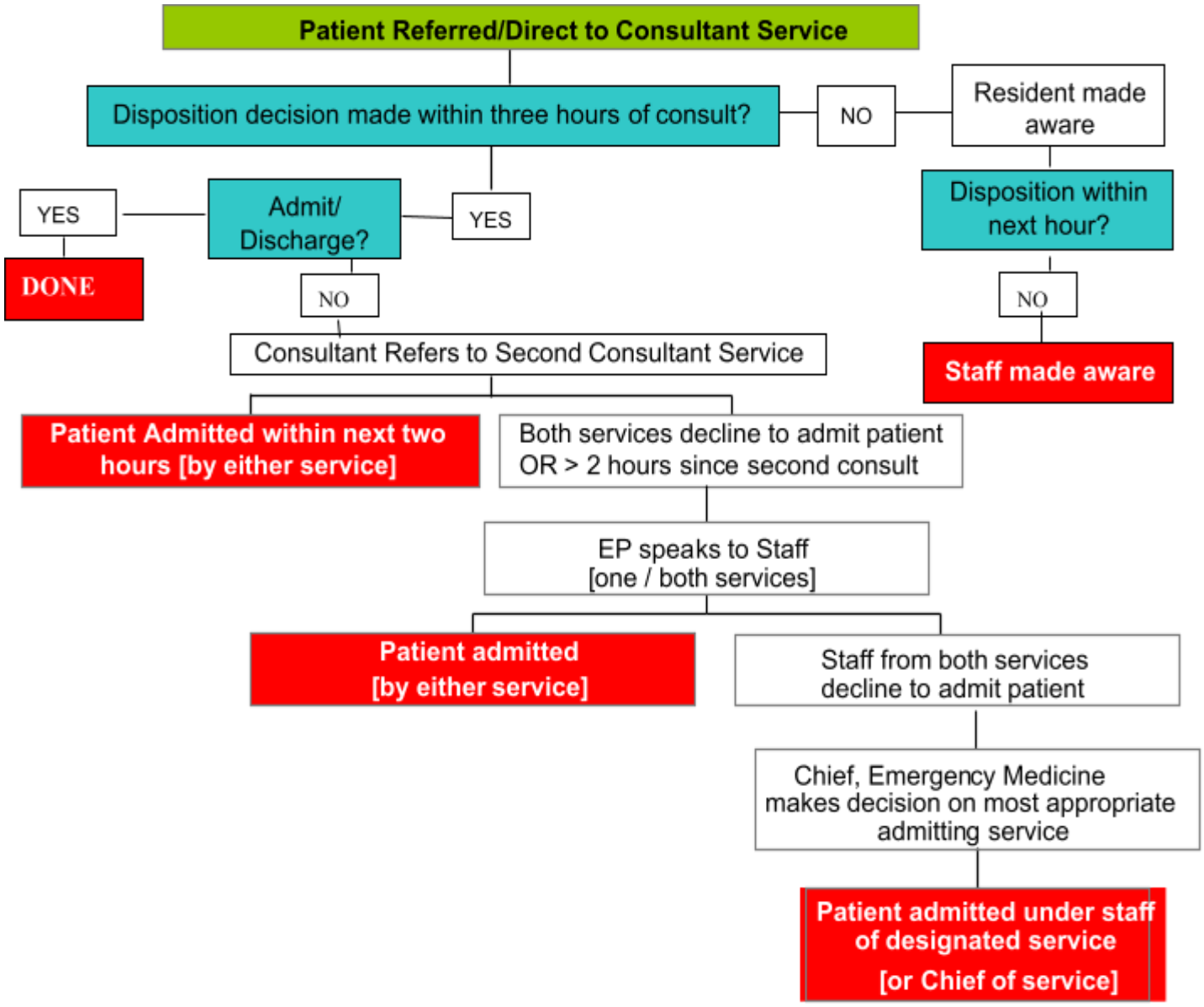
   - Holding orders will be written

   - The patient will be moved to an available bed as soon as patient condition allows

6. Service-specific response times will be regularly reported to the MAC and Chiefs.

7. The subspecialty consults team (SCT) provides coverage for the following inpatient wards: Nephrology, Respirology, Heme/Onc, and GI. For admissions to these services, please page the SCT through Locating.

Process Map for Admissions via the ED



Returning Patients

For ED Assessment:

Patients that return to hospital after a recent discharge ("bounce-backs") should be assessed by the discharging team with no need for assessment by an ED MD if:

- Discharge occurred **within the last 24 hours**
- Patient is stable and no emergency issue to be dealt with

If the discharge occurred **over 24 hours ago**, then the patient must be assessed by the ED MD first, before the decision is made to refer to an admitting service. If, after the ED MD's assessment, the patient requires admission, please follow the "For Admission" rules below.

For Admission:

Patients that return to hospital after a recent discharge ("bounce backs") should be referred to the discharging service if within the below timeline and if their presenting complaint is related to their recent admission. Please note, if the "bounce-back" patient was discharged >24hours ago, the patient must be assessed by ED MD before referral to an admitting service.

1. Patients discharged from general internal medicine or cardiology within 14 days
2. Patients discharged from surgical services or psychiatry within 7 days

Cardiology – GIM

All patients seen by a SMH cardiologist **in the past two years** who present to the Emergency Room with a cardiac chief complaint and requiring hospital admission will be referred to Cardiology. If the most responsible admission diagnosis is non-cardiac, then the patient will be referred to General Medicine *by Cardiology* for admission and will be reviewed with the GIM staff. When a patient known to the Cardiology service is admitted to Team Medicine, the staff cardiologist will be notified. Concurrent care and cardiology consultation will be determined on a patient specific basis.

Cardiology will automatically be consulted for all patients admitted to GIM with suspected **endocarditis** or **heart failure secondary to a newly identified or severe valvulopathy.**

CARDIOLOGY REFERRAL

Examples of patient presentations that are referred to and admitted **solely to the cardiology service** if seen by an SMH Cardiologist in the last two years**:**

1) Congestive heart failure or pulmonary edema as primary presentation
2) SVT (Including A. Fib. And A. Flutter) as primary diagnosis
3) Syncope NYD
4) Arrhythmias requiring continuous monitoring
5) Hypertensive Emergency

Examples of patient presentations that are referred to and admitted **solely to the cardiology service regardless of a past affiliation with a SMH cardiologist**. The disease must be active and the reason for hospital admission.

1) Acute Coronary Syndromes—compatible symptoms as primary presentation associated with troponin rise and/or ECG changes
2) Chest Pain for diagnosis - ischemic sounding chest pain as primary presentation in absence **of** ECG changes/troponin elevation and in the absence of other potential causes, eg. pulmonary embolus
3) Unstable congestive heart failure (where CHF is cause of instability) - requiring acute therapy in addition to diuretics (bipap, ventilation, pressors, significant tropinin – e.g. > 3)
4) All pts whose presenting syndrome is thought to be due to significant valvular heart disease (including endocarditis)
5) All serious primary ventricular arrythmias
6) All primary second and third degree heart block
7) Unstable SVT (incl. A.Fib. and A. Flutter)
8) Pacemaker or ICD failure
9) Cardiac Tamponade

INTERNAL MEDICINE REFERRAL

Examples of patient presentations that may be referred to **internal medicine**. (If NOT seen by SMH Cardiologist within last two years)

1) Stable congestive heart failure as new diagnosis responding reasonably well to diuretic therapy in the ER
2) Stable congestive heart failure in association with other serious medical conditions (eg COPD, pneumonia)
3) Stable congestive heart failure as primary diagnosis associated with minor troponin rise which is thought to be secondary to heart failure (Example: Demand related Troponin elevation <3)
4) Stable SVT (including A. Fib. Or A. Flutter) as primary diagnosis. 5) Syncope NYD

Examples of patient presentations that may be referred to **internal medicine regardless of past affiliation with SMH Cardiologist.**

1) Unexpected troponin elevations not thought to be ACS (For example, demand related Troponin elevation < 3) in association with serious medical illness such as pneumonia, PE, sepsis, etc)
2) SVT if secondary to general medical illness (associated minor troponin rise acceptable)
3) Congestive heart failure secondary to, or coinciding with other serious medical conditions (COPD, pneumonia)

10) Suspected aortic dissection	

Cardiology

Arrhythmia		
• Hemodynamically unstable	All	Cardiology
• Pacemaker/ICD Failure	All	Cardiology
• 2nd/3rd degree heart block	All	Cardiology
• Serious Ventricular	All	Cardiology
• Stable SVT (Incl. A.Fib/Flutter)	Seen by SMH cardiologist within last 2 years	Cardiology
	All others	GIM
Syncope NYD	Seen by SMH cardiologist within last 2 years	Cardiology
	All others	GIM
ACS /Ischemic Syndrome	All	Cardiology
CHF	Unstable OR ECG changes OR significant +ve troponin thought to be ACS (e.g. >3)	Cardiology
	Seen by SMH cardiologist within last 2 years	Cardiology
	All others (even with minor troponin rise, e.g. <3)	GIM
Cardiac medication-related toxicity	All	Cardiology
Symptomatic valvulopathy (Incl endocarditis)	All	Cardiology
Hypertensive emergency	Seen by SMH cardiologist within last 2 years	Cardiology
	All others	GIM
Nonoperative Aortic Dissection	All	Cardiology

Gastrointestinal Disease

GI Bleed	If unstable	MS-ICU
	If from a known surgical lesion	General surgery
	All others	GIM
Diverticulitis	All	General surgery
Bowel obstruction	All	General surgery
Pancreatitis	If from gallstones or other obstructive cause	General surgery
	All others	GIM
Hepatitis or liver failure	If followed by GI for this	GI
	All others	GIM
Alimentary foreign bodies	Require surgery	General surgery
	All others	GI
Inflammatory bowel	If followed by GI	GI
	All others	GIM
Acute cholecystitis	All	General surgery
Cholangitis	All	GI
Choledocholithiasis	All	GI

Genitourinary / Renal Disease

Pyelonephritis	In the setting of (1) infected renal stone or (2) obstruction	Urology
	All others	GIM
Dialysis (PD/HD)	CHF, electrolytes disturbance, sepsis of unknown source or line sepsis. PD patient with peritonitis. PD access issue	Nephrology
	Fistula/vascular access problem	Vascular surgery
	Reason for admission is an issue for which presence of dialysis is incidental	Appropriate subspecialty as outlined elsewhere in this document
	All others	GIM

Hematology / Oncology

Note: Oncology patients presenting with problems unrelated to an active cancer, or who are **not** followed by an SMH Oncologist should be referred to the most appropriate service for their acute condition.

Congenital bleeding disorder (With active/recent bleed)	All	Hematology/ Oncology
Acute or palliative oncology problem	Acute structural Problem (e.g. bowel	General surgery obstruction)
	All other problems **Followed by SMH Oncologist**: (including DVT/PE) OR Hematology/ oncology treatment complication OR suspicion of recurrence	**NOT Followed by SMH Oncologist**: Internal Medicine
	Unrelated to active cancer	Most Appropriate service as per remaining guidelines

Miscellaneous

Cellulitis	Upper extremity	Plastic surgery
	Face	Plastic surgery
	Requiring surgical procedure e.g. debridement, I & D	Plastic surgery
	All others	GIM
Osteomyelitis (see Spinal Infection section for spine OM)	If post-operative	Original service
	Septic/unstable	GIM/ICU
	All others	GIM
Parotitis	All	ENT

Addendum: Memorandum of agreement (Drs. MacDonald, Hyland, Mourad)

Spinal osteomyelitis/epidural abscess		Neurosurgery
Back or neck pain	Neurological deficit or lesion Requiring surgery or patient previously seen by staff neurosurgeon	Neurosurgery
	All others (eg. Pain control)	Internal medicine

Nephrology-GIM Clarification & Agreement

1. Peritoneal Dialysis patients presenting with an issue relating to dialysis or with peritonitis are referred to Nephrology.

2. Unless direct to nephrology, renal treatment patients presenting to ER with a medical/surgical issues are to be referred to the appropriate service as per ER guidelines. Nephrology should be consulted first for the treatment patients with AKI and those presenting with fever/infection.

3. Patients on GIM who have been initiated on renal replacement therapy in hospital will be transferred to nephrology once their acute medical issues have been stabilized.

4. The disposition of patients in MSICU who have been initiated on renal replacement therapy will be dealt with on an individual basis.

Renal Transplant Admissions

(To be decided by Nephrology resident <u>after</u> consult)

<u>To Nephrology</u>

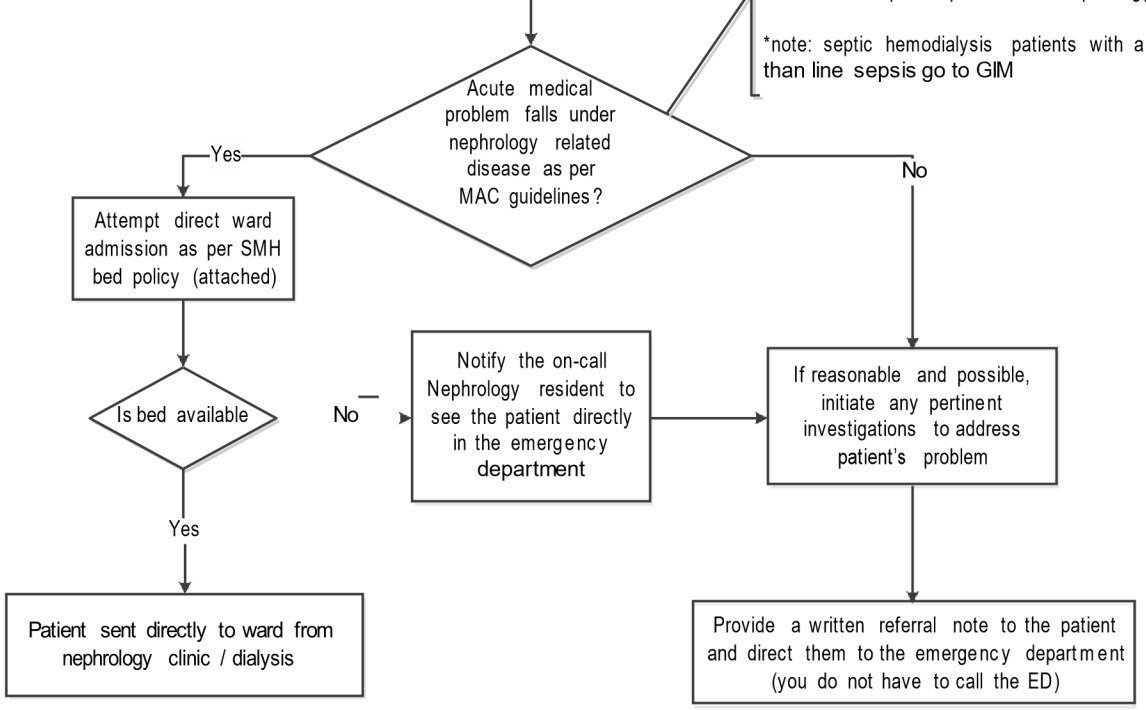
1. **Admission for Transplant**
2. **Acute Rejection**
3. **All Infections/Sepsis**
4. **AKI not otherwise explained**
5. **Anti-rejection drug toxicity**

<u>To Team Medicine</u>

1. **Diabetes**
2. **Non TPA stroke**
3. **GI bleed**
4. **Malignancies excluding PTLD**

If a patient is seen by a nephrology MD or resident in <u>the dialysis unit</u> and sent to the ED for admission to nephrology, the ED physician does not need to assess the patient. If the nephrology MD believes the patient should be admitted to GIM (e.g. for Community Acquired Pneumonia), **the staff nephrology MD should directly call the staff GIM MD** to communicate this plan. The patient will be sent to the ED "Direct to Medicine" from the dialysis unit.

If a dialysis patient comes to the ED independently (e.g. by ambulance, not from the dialysis unit), the ED physician should assess and refer to the most appropriate service as per the consult guidelines above.


*note: septic hemodialysis patients with a known source other than line sepsis go to GIM
Acute medical problem falls under nephrology related disease as per MAC guidelines?
Yes
No
Attempt direct ward admission as per SMH bed policy (attached)
Is bed available
No
Notify the on-call Nephrology resident to see the patient directly in the emergency department
If reasonable and possible, initiate any pertinent investigations to address patient's problem
Yes
Patient sent directly to ward from nephrology clinic / dialysis
Provide a written referral note to the patient and direct them to the emergency department (you do not have to call the ED)

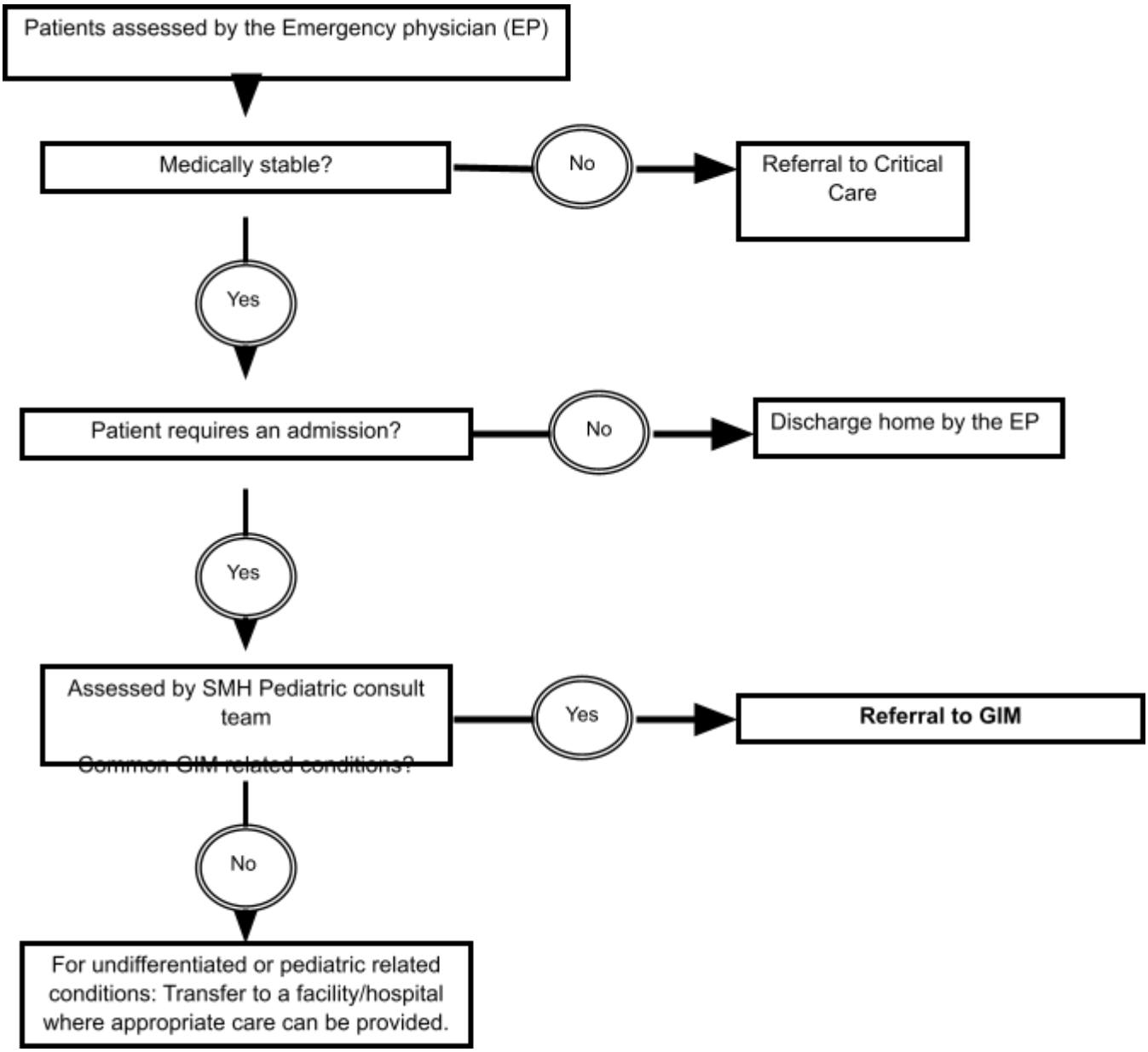
Neurological Disease

Stroke/ high-risk TIA

Undergoing TPA/EVT	Stroke
Subacute stroke or high risk TIA (ABCD2>4) --Not candidate for TPA/EVT --Main reason for presentation to hospital	Stroke

Seizure	Status epilepticus, CT +'ve	Neurosurgery
	Status epilepticus, CT –'ve	Neurology
	All others	GIM
Acute intracranial bleed	Operable/to assess operability	Neurosurgery
Non-operative ICH	Non-traumatic (spontaneous), non-operative (including palliative care)	Stroke or ICU after neurosurgery assessment
	Traumatic, non-operative (including palliative care)	GIM after neurosurgery assessment

Admitting Pediatric Patients Aged Between 16 and 17 from ED



Respirology

NOTE: Patients presenting with large volume hemoptysis or an underlying diagnosis of Cystic Fibrosis are always referred to Respirology. Admission to Respirology or Medicine for patients presenting with other respiratory conditions, known to Respirology (seen within the past year) will otherwise be determined by the daily census.

Hemoptysis	Massive / unstable	MSICU
	All others	Respirology
Complications of cystic fibrosis	All	Respirology
COPD/ asthma	If seen by a SMH respirologist within the last year	Respirology
	All others	GIM
Bronchiectasis	If seen by a SMH Respirologist within the last year	Respirology
	All others	GIM
Pulmonary hypertension	If seen by a SMH respirologist within the last year	Respirology
	All others	GIM
Pulmonary fibrosis/ interstitial lung disease / Bronchogenic carcinoma	If seen by a SMH respirologist within the last year	Respirology
	All others	GIM
Bronchiectasis	If seen by a SMH respirologist within last year	Respirolgy
	All others	GIM
Pulmonary embolism	Hemodynamically Unstable / thrombolysis	MSICU
	Not related to malignancy	GIM
	related to active cancer	**Followed by SMH Oncologist**: Hematology/ oncology

Respirology Continued

All patients seen by a staff SMH respirologist in the past year who present to the Emergency Room with a respiratory chief complaint, and require hospital admission will be referred to the *Respirology Service or GIM* depending on the daily census of each service (see below).

1. If the most responsible admission diagnosis is hemoptysis or related to the care or complications of patients with cystic fibrosis, then the patient will be admitted under the care of the respirology service.

2. If the most responsible admission diagnosis is not pulmonary related, then the patient will be referred to General Medicine for admission and will be reviewed by the medical team with the GIM staff.

3. The Respirology attending staff will always be available by telephone to discuss the evaluation and management of Resp patients requiring admission (both to Team Medicine and Respirology). Furthermore, when a patient known to the Respirology service is admitted to Team Medicine, the staff respirologist will be notified that their patient has been admitted to GIM. Concurrent care and respirology consultation will be determined on a patient specific basis.

Examples of patient presentations that are referred to and admitted **solely** to the respirology service **regardless of a past affiliation with a SMH respirologist**. The disease must be active and the reason for hospital admission. •**Hemoptysis** •**Complications of Cystic Fibrosis**	Examples of conditions that may be referred to respirology if a patient has been **seen by a SMH respirologist within the last year**. •COPD/Asthma •Complications of therapy for a primary pulmonary diagnosis [e.g. tuberculosis] •Bronchiectasis •Pulmonary hypertension •Pulmonary fibrosis/ interstitial lung disease •Bronchogenic carcinoma •Thrombotic disease

Medicine/Respirology Daily Census modifiers (updated July 2022):

Patient requiring admission with a respiratory issue known to a SMH respirologist:

Medicine Census	Respirology Census	Accepting Service
Anything	< 15	**Respirology**
< 75	> 15	**GIM**
> 75	16-19	**Respirology**
Anything	> 20	**GIM**

Spinal Infection (discitis, osteomyelitis, epidural abscess)

Revised Guidelines *(reviewed and agreed by Drs. H Ginsberg, H Ahn, J Wilson, C Witiw, Y Lee, V Dounaevskaia on April 22 and reviewed at the GIM staff meeting on May 04 2022)*

MRI of the spine should be performed in the ED before deciding about patient disposition if OM/discitis/epidural abscess is suspected.

If MRI shows spine infection, the ED physician consults the Spine Service (SS) first.

Thereafter, if appropriate, GIM is consulted after a note by the SS staff is signed off on EVR.

Spine Service admits:

1) Spine infection with cord compression or neurologic deficit
2) discitis or osteomyelitis in cervical spine 3) Epidural Abscess

GIM admits:

Discitis or osteomyelitis in thoracic or lumbar spine (after SS assessment)

This will be implemented on May 16 2022 and in effect for one year. It will be reassessed and revised if needed.

Traumatic

Hand injuries	All	Plastic surgery
Spinal trauma	All	Spine service on call
Inability to ambulate	Primary reason for admission is the presence of active fracture (includes stable fractures e.g.: pubic ramus fracture) Primary reason for admission is due to a medical issue normally referred to subspecialty service Neither of above	Orthopedic surgery Appropriate service outlined elsewhere in document Internal medicine
Rib fracture(s) requiring admission for pain control and observation	All	General surgery