LACGH Hospitalist Orientation Manual

Welcome to the LACGH ACU family! This document is intended for medical students, residents and new staff physicians. It highlights important information about working on the acute care unit (ACU) at LACGH!

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Important items Prior to Starting as a hospitalist

Please Ensure you Have:

- All your privileges approved (for staff physicians)
- Had your IT training and login for LUMEO
- Your ID and access badge
- Setup your remote access via the I.T. Department
- Setup your Metricaid scheduling login and review your hospitalist schedule
- Reviewed this orientation manual

General Information:

- LACGH Services include:
    - Diagnostic Services:
        - 24/7 **laboratory services**
        - 24/7 **xray services** (overnight is often on-call xray tech)
        - **U/S and CT** are available 7 days per week daytime/evening
        - **MRI** is available during weekdays
        - **POCUS** – There is a POCUS U/S Machine for the ACU housed in the ICU. There is also a machine in the ED that we can ask to borrow (if not being used by ED) in cases where the ACU machine is not working or not generating optimal images.
    - Emergency Department
    - Acute care unit
    - 4 Bed level 2 ICU
    - 2 Palliative care suites
    - Surgical services: emergency & elective – variety of surgical specialties but the main focus is General surgery
    - Internal medicine – provide consulting services, outpatient clinics, rapid access emergency department clinic, post-discharge clinic **in collaboration with NP.
    - Outpatient clinics – variety of services.
    - Diabetes program
    - Cardiac services including stress testing and cardiac rehabilitation program
    - Convalescent care Program
    - Interventional radiology program
    - Chemotherapy/oncology satellite site

- The hospitalist medical team is usually made up of 2-3 hospitalist staff, residents (typically 1 to 2 residents doing either a week or a month-long elective) as well as medical students who occasionally do rotations with our service.

- We have a "hospitalist room" on the Acute Care unit with multiple workstations and resources – this is where we do most of our documentation work.

- Basic Hospitalist Responsibilities for the week:

    - Care as MRP for patients (split between the 2-3 staff hospitalists)

    - Ensure someone is on-call 24/7 – MRP call split between the staff hospitalists (call scheduled is organized at the start of the week)

- LACGH has an acute care unit that includes acute medical/surgical beds, 2 palliative care suites and a 4-bed level 2 ICU. Volumes of admitted patients typically range from mid 30s to mid 40s with short-term periods above and below these ranges. Not all these patients are actively medical. A large proportion of these patients will be designated ALC (alternative level of care), typically in the 10-15 range, but sometimes up to high teens - ALC patients do not require "hospital level medical care" but are awaiting an alternate disposition. A small number of patients may be under the care of our general surgeons as their MRP.

- We have a level 2 Basic ICU with 4 beds. These patients are automatically consulted and co-managed by our internal medicine specialists. We do not care for patients on mechanical

ventilation. Patients requiring this level of care in our ED will not be admitted and transferred to another institution via criticall (most of the time the hospitalist are not involved at all in these cases). If an ICU patient requires intubation, this would typically be done by our anesthesiologist or emergency physician colleagues depending on the scenario.

    - Patients that are regularly admitted to ICU would include sepsis on pressors, CHF/COPD exacerbation requiring BIPAP, DKA patients, severe alcohol withdrawal, multi-organ failure, those with concerning arrythmias or high-risk MI etc. Internal medicine is available to help inform management and decide on disposition for patients. On rare occasions we will accept admission to our ICU from other institutions, but this is always done via our interna medicine specialist on-call.

- We have two palliative care suites which are located in the convalescent care (rehab) section of the hospital connected to the acute care unit. They have a pull-out bed for families to sleep in and separate washrooms for family members and patients. There is a small kitchenette that can support basic food preparation. We remain MRP if a medical patient becomes palliative and we are MRP for any patients admitted for palliation.

- We have two negative pressure rooms, one in the ICU and one on the ward: ICU-1 and room 102. These can be used for any infectious disease requiring negative pressure/airborne precautious.

- LACGH also houses a convalescent care unit which sometimes houses ALC (Alternative level of care). There is a dedicated nurse practitioner and physician during the week caring for convalescent care patients, however the hospitalist team is occasionally asked to assess or manage these patients during the weekend. They can be sent to the Emergency Department as well if they are more acutely unwell.

Specialties at LACGH:

**You can determine who is on-call by reviewing master-call list typically posted by the CLERK desk or charge nurse desk. This is also available via Metricaid (the same app that schedules all hospitalist rotations)

- In house:

    - Internal Medicine: IM at LACGH is a consulting service, they do not admit under themselves directly except in very exceptional cases. There is always someone on-call for IM covering consults for ED, ACU and ICU. They are automatically consulted on all patients who are put in the ICU, though we should still let them know about all ICU admissions. In addition to the inpatient ward, they also have day clinics and do stress tests. They are very closely involved with the hospitalist team so much of the communication with them is informal and ad hoc and done throughout the day. It is always important to “close the loop” of communication by confirming with internal medicine WHO will be inputting orders to ensure that diagnostic tests or therapeutic interventions are not delayed.

    - General Surgery: General surgeons are on call 24/7 for consultation and emergency surgeries. For purely surgical cases, the general surgeon will often remain as MRP but this practice can vary depending on factors including the specific surgery, the surgeon

on-call, timing and preference. It is important to clarify MRP with the surgeon if there is any uncertainty. There are some cases that frequently require input from surgeons such as for GI bleeds (may require endoscopy/colonoscopy) diverticulitis (may at times require surgery), or gallstone pancreatitis but these are generally admitted under hospitalist as MRP with surgeons as consultants. It is important to consult surgeons early to help inform care, as well as determine if a patient is a suitable candidate for surgery at LACGH or if they will require transfer to another institution (a shared decision between surgeon and anesthesiologist)

- Anesthesia: Anesthesia is available on-call to help manage airway concerns and also to assist in transferring critically ill patients. There is also usually an anesthesiologist in-house assisting with surgeries. They can assist with: Airway concerns, Transfer of patients and are occasionally involved with rare complex pain management challenges (nerve blocks, ketamine infusions etc)

- Neurology: We have one neurologist on staff at LACGH, Dr. Matthew Mercier. He can do inpatient consults on a non-urgent basis but is not on-call for urgent cases. For any urgent neurological cases, please consult the on-call neurology team via KGH. Please note that there are two consulting neurology services at KGH stroke and non-stroke. It is important to consult the appropriate service to avoid delays.

- Radiology: We have a radiologist in house during regular business hours. They can do some IVR procedures (PICC lines, difficult joint injections, para/thoracenteses). They are also happy to go through an imaging study with you if you have questions about a report.

- Other specialties: We also have many specialties (urology, plastics, respirology, gynecology, hematology) who come to LACGH one or two days a week to do outpatient clinics. If you let them know very early in the day and they have time, sometimes they can do one-time non-urgent inpatient consults (eg. A difficult foley insertion for urinary retention that requires cystoscopy-guided insertion can occasionally be done at LACGH if a urologist happens to be doing a clinic that day).

Daily Workflow:

- Weekdays typically start at 0830 rounds. Staff/residents will arrive earlier to print lists, quickly review any urgent issues prior to rounds.

- The first event of each day is team rounds. The Hospitalist Team, the charge nurse, pharmacy, social work, physiotherapy, occupational therapy, dietician and RT all gather on the 2nd floor to do “bullet rounds”. Generally, these rounds are geared more towards interfacing the medical team with allied health with an emphasis on disposition and discharge – this can include a very brief medical update for new patients but is not required for patients that are well known to the service already.

    - Once a week these rounds take the shape of interdisciplinary weekly status exchange where we focus on quality improvement, problem solving and review important strategies priorities for the acute care unit.

- As of July 2025, we have started daily “pre-discharge huddles” at 2pm near the charge nurse desk, where we quickly review expected discharges in the next 24hrs to ensure there are no outstanding issues or barriers to discharge.
- Patients are usually seen once per day, and an admission H&P note, progress note or discharge summary is written for each patient once per day.
- Priority goes to managing sick/acutely unwell patients first, and then discharges are prioritized to enable flow through the hospital from ED to ACU.
- Admissions that come in during the day are usually seen during the same day. Depending on how quick we get to them, they may still be in the ED when they are seen or on the ward already.
- Admission orders are typically done by the hospitalist team during daytime hours and the emergency physician will typically put in holding admission orders in the evening/overnight. Please try and put in some preliminary admission orders in a timely fashion as this helps move patients from the ED to the inpatient unit in a timely fashion. **It is important to comprehensively review all orders for a new admission even if put in place by the ED physician to ensure that nothing is missed as the MRP is responsible for all orders for an admitted pati
- There is no specific time when the day is done. Generally, each member of the team leaves when their work is finished.
    - **For residents:** Check with the staff before leaving for the day in case there is anything pending. Most days, work is done by 1700-1800, however if it is very busy and we get a lot of admissions late in the day, you may be asked to see one.
- If you order tests or imaging during the day, it is expected that you will follow up on them later in the day once they are complete. You can add an addendum to your earlier progress note if you want to document the results.

Documentation:

- You must document all clinical interactions. You will receive Lumeo training for this. Common documenting templates will be:
    - History and Physical (for admission assessments)
    - Inpatient progress notes (daily documentation).
        - If you see a patient a subsequent time, you can document an addendum.
        - If important labs/diagnostic tests arise, it is important ot document then as an addendum
    - Discharge Summary
    - Letter (Provider Note) (if you are referring someone to a consultant at a different institution). **Depending on the services/consultant this may require a paper referral or a LUMEO referral, please check with a colleague/clerk/charge nurse if you are not sure.
- WOW – Please note there is a mobile “workstation on wheels”/WOW available for physicians to use on the ACU if you prefer this over the regular hospitalist room workstations.

Process for New Admissions:

- **Admission process guidelines (for residents):**
    - Fully Evaluate the patient
        - full history and physical including a review of documentation in our system, KGH system, clinical viewer as indicated.
        - Review all diagnostic tests and review treatment provided in the ED
        - Develop your impression and plan including:
            - Differential diagnosis for ALL issues
            - Additional investigations required
            - Treatment plan
    - Clarify, discuss and ensure you enter **an ORDER for GOALS OF CARE** (the GOC classification is embedded into the Lumeo GOC order)
    - Decide on **DVT prophylaxis**
    - Try to order critical/urgent medication as soon as safely possible. **Do not do the Admission Medication reconciliation until the BPMH is completed by a pharmacy staff member. **refer to Lumeo/IT training for details.**
    - Ensure admission orders are completed (preliminary basic orders are frequently put in prior to full evaluation to facilitate transfer of a patient from the ED to inpatient unit).
    - As a general rule, we do not directly admit any patients so all admissions would go through the ED.

- Most calls for admissions will be before midnight or from 0700-0800 as the ED physicians often try to avoid waking us up and will hold onto them until the morning.

- The ED physician will call and give you a history, review rx etc. This is an opportunity to ask questions re: admissions, additional testing or treatment that may be beneficial prior to the hospitalist team assessing the patient.

- **For residents on-call.** Please confirm with your staff if they wished to be called for every admission. Some staff prefer to be called for all admission, some only for sicks ones, some prefer text-message notification etc.

- If the admission sounds quite sick and you want to discuss with hospitalist staff:

    - Ensure you tell them that before we accept the patient for admission you would like to discuss with hospitalist staff and will call them back to let them know.

    - Ask if the ED physician discussed code status.

- At rounds the next morning, you will be expected to give a brief overview of the story you got from the ED physician (obviously it will be vague as no one has seen them yet).

- New admissions from the previous night are divided amongst the team after rounds.

Admission Special Cases:

- Hemodialysis: The dialysis clinic in Napanee will not dialyze one of their patients if they are admitted under ANY circumstances. If the admission is almost certainly going to be just 1-2 days and they are not scheduled for dialysis in that time, we may admit here. Otherwise, it is much

easier for them to be admitted to KGH directly. Discuss any hemodialysis patient with staff before accepting.

- Peritoneal Dialysis: These patients need to be completely capable of doing their own peritoneal dialysis (or have a caregiver who can commit to doing all the Peritoneal dialysis care) to admit to LACGH as we don't reliably have staff with PD training (ie: the patient/caregiver cannot be confused at all and must be fully capable and reliable). They will need to bring their own PD supplies into the hospital with them. If they are confused or their delegate cannot come into hospital reliably then they need to go to KGH.

- ***Uncertainty re: accepting an Admission:***

    - **For Residents:** If you are unsure if the patient is too sick (ie. May need intubation, dialysis then please say you wish to speak to your staff first before deciding, however the ED physicians generally have a good sense of who is a candidate for LACGH vs. another institution.

    - **For new staff**: If you are unsure if an admission is appropriate for LACGH then internal medicine is often consulted verbally to determine if they are suitable for admission to LACGH ICU or not.

- **Repatriations:** There is a different formal process for repatriating patients back to LACGH From other institutions. This process is managed by the charge nurse. They will inform the hospitalist when we have capacity to repatriate a patient in accordance with regionally developed protocols. For this process you will obtain handover from a physician or NP from another institution prior to accepting the patient. These patients do NOT go through the ED and are admitted directly to the acute care unit. The hospitalist must ensure all orders are in place as per usual process. Repatriations are often pre-admitted prior to their arrival so you can place orders and review medications prior to their arrival.

Weekend Process & Expectations:

- Staff MRP will round on Saturday and Sunday. Resident/Medical student may be working on a weekend depending on their resident schedule and the nature of their rotation (ie. 1 week vs. elective etc).

- On the weekend days, start time varies by hospitalist staff preferences. Most will still start around 0830-10h00.

- There are no group rounds, we start seeing patients when we get there and leave when we are done.

- Physiotherapy assistants will work with patients over the weekend. OT, Social Work, Pharmacy, and the dietician typically do not work on weekends.

- We do have an on-call pharmacist over the weekend through a third-party agency. Call the switchboard and ask to speak with the on-call pharmacist if you need to during the weekend.

- CT, Xray, U/s and Lab services operate as normal on weekends.

Covid/Infectious Disease:

- We used to have major COVID and infectious disease policies but at this time we are essentially operating in a pre-covid fashion.
- It is still relevant to perform appropriate viral swabbing on appropriate patients.
- Our IPAC team typically manages isolation of patients, but may require input from the MD. It is important to notify nursing and IPAC lead if you have concerns over high-risk infectious disease such as high-risk covid, measles, TB etc.
- It is important to ensure you have been fitted with N95 mask/respiratory. If not, please reach out to IPAC team.

On-call responsibilities:

- Call is split between staff and residents, although there is always a staff physician on-call.
- Call is done at home. The hospital will call you on your cell phone directly.
- As the call is home call and generally light, there are no post-call days for staff or residents.
- Usually, residents will do 1-2 days of call per week and one weekend night call (but if a resident is working that weekend they will round on both days with the team) during the block. This depends on their rotation and PARO rules for that week.
- The call schedule is made up by the incoming team each Tuesday.
- Call responsibilities:
    - ***ACU issues and Admissions:***
        - You will be first call for both floor issues and new admissions. This is almost always done remotely from home, but on occasion requires the staff hospitalist to come in to manage a sicker patient or a sig volume of admissions.
            - Residents are not expected to come in overnight as there is no post-call day. Staff hospitalist must be prepared to come into the hospital but this is generally uncommon overnight.
        - You will field calls for new admission from ED physicians typically before midnight (*after midnight they are often held until the AM).
            - New admissions are typically seen in the morning unless they are unstable, or the emergency department is slammed.
    - ***Surgical Assisting for Emergency Surgeries:***

        - Staff hospitalists are responsive for Surgical assisting responsibilities for emergency surgeries (not daytime elective surgeries)

- We are not supposed to manage patients who are admitted under one of the General Surgeons. Nursing staff sometimes call us out of habit as the Surgeons don't have many inpatients and often have no admitted patients under themselves. If you get called, ask nursing to call the General Surgeon instead.

- If a palliative patient dies expectedly, we do not need to come in to pronounce. We will fill the death certificate out and put in a brief discharge summary in the morning. Most nurses will not call you for this, but sometimes new ones aren't aware of the protocol.

On-Call Floor Issues (Guidelines for Residents and new staff):

- For mild floor issues (ie: Tylenol orders, sleeping pills, home medications that weren't ordered by emerg): These can be given vial verbal order OR feel free to log into MediTech and put in the orders if you feel it is appropriate.

- For sick patients overnight, if you feel comfortable, you can manage the problem remotely. If you feel at all uncomfortable, call your staff and/or internal medicine on-call.

    - We can do bloodwork and ECG at any time. X-rays (only before 23h30, otherwise must call in the Xray Technician) and ECGs overnight.

    - You can check blood work results on MediTech. As we are a rural hospital, some tests that need to be done at KGH are only sent in regularly scheduled couriers, so the lab tech may request leaving some of them until morning bloodwork. If the test is critical, then confirm verbally with the lab and they can get a taxi to transport it to KGH immediately.

    - X-rays can be checked via PACS Web Viewer, which is on the remote access interface. Make sure your login for this is working before leaving the hospital.

    - ECG and Labs can be checked via the LUMEO EMR.

- For life-threatening floor issues (ie: peri-arrest, critically unwell, a patient you think needs to be managed ASAP) tell the nurse **to call the emergency department and ask the ED physician to come over. Then tell them you are going to try and call the ED physician as well**. Hang up and call the emergency department (ext. 226 or 814). Give the emergency department physician a brief history if you know it and ask if they can see the patient now.

- For Residents: please notify our staff immediately of any urgent/emergent/critical patient concerns or results.

Expectations for Coming in to assess a patient overnight:

- Residents are not expected to come into the hospital overnight. If a patient sounds sick enough that they need to be seen in person, the staff physician will come in. This is to prevent time delays before the staff physician is alerted to the problem, and it is dealt with.

You can come in in addition to the hospitalist staff if you are keen to learn or participate in managing an unstable patient, but this is not an overnight on-call expectation. There are also no “post-call days”

- For residents: In general, the only way you can make a mistake while on call is to not call staff when you are unsure of what to do. We are generally more hands on and expect to be more involved on call than the staff at the tertiary care centers. We don’t have residents every week, so we are used to being on call every other night.

Important Phone extensions:

- LACGH Main Line: (613)354-3301
- Switchboard: 0 (Switchboard will be answered by an operator from 0700-2100, overnight 0 will bring you to the nursing desk in the Emergency Department).
- Emergency Physician: 226 or 814 (ascom)
- Hospitalist physician ASCOM (811 or 845)
- Medical Ward Charge Nurse: 812
- ICU nurse: 245
- Ward nurse: 236 (this is the phone beside the ward clerk, a nurse usually sits here during the evenings). Each nurse carries their own portable phone with extensions 806-809. Ask for their ASCOM number if you will need to reach them again.

Remote Access:

- Please liaise with I.T Prior to your hospitalits week to ensure you have remote access setup including the proper link, software, phone authenticator, login and passwords. This is Critical to be able to manage on-call issues including reviewing notes, diagnostics tests and placing proper orders.

Scheduling:

- Our call schedule is done via MetricAid (https://www.metricaid.com/). Make sure your contact information in your MetricAid profile is complete so people can easily contact you on call.
- Dr. Molly Touzel is the primary point of contact for scheduling requests by either staff or residents.

LUMEO EMR Transition

- LACGH transitioned to a new EMR system via Cerner called Lumeo in December 2024 along with most regional hospitals. For resident physicians, please speak to your staff for relevant updates/changes as they occur frequently in the transition periods. For new staff physicians, please reach out to Dr. Robichaud and Dr. Glatt for a link on recent updates regarding LUMEO challenges.

Evaluations:

- Evaluations are done by Dr. Robin Britton (robin.britton@lacgh.napanee.on.ca) with input from the staff you worked with. Liaise with Dr. Britton if you have any questions or concerns regarding evaluation -

- If you have any feedback about ANY aspect of the rotation, please contact Dr. Britton. We are always looking to improve the rotation. You could either let me know in person if I'm around or via email (Feedback is 100% confidential. If there is feedback about a particular staff, I will only raise it with them many months after your rotation is finished to ensure source anonymity.

If there is feedback about Dr. Britton you can send it to Dr. Pierre Robichaud (probichaud@lacgh.napanee.on.ca) who will respect the same confidentiality and feedback process.