Clinical Pathway – QEII IMCU Flow during COVID-19 Pandemic

**Principle:**
As long as possible cohort COVID-19 IMCU patients and non–COVID patients separately.

**Goal:**
To minimize spread and minimize PPE use.

**Available space:**
- **6.1 IMCU:** 18 beds all monitored, 2 dialysis rooms. 6.1 has capacity for non–cardiac patients and Cardiology/Heart Health agreeable to manage non–cardiac IMCU level patients there with the help of appropriate specialists. The plan is to use these beds for Medicine IMCU patients and acute dialysis patients with non–nephrology primary cause (details below).
- **7.3 (mainly used for Neurosurgery):** Neurology able to manage patients there if there is the capacity.
- **7.1:** Could send Surgery and Vascular patients (Closed IMCU). Use for GI bleed patients (General Surgery will be MRP for these)
- **7.2:** Good about off service. Open IMCU. Could use for GI bleed patients (General Surgery will be MRP for these)
- **4.1:** GI bleeds (General Surgery will be MRP for these)

**Consult Pathway for IMCU patients During COVID:**

**Patients with COVID 19 needing IMCU level care:**
- Patients coming through the ED or from inpatient units, if COVID suspect or COVID positive and need IMCU care (regardless of diagnosis) consult ICU triage physician. They will decide ICU vs. COVID 3IMCU

**Non–COVID patients needing IMCU level care:**
- Surgical patients coming through ED – Use the usual surgical pathway.
- Patients coming through ED with GI bleed – Assessing physician consults GI for upper GI bleeds and HI General Surgery on call for Lower GI bleeds (see IMCU GI bleed details below)
- DKA patients that cannot be managed in ED in reasonable time go to MTU
- All other Medicine Patients coming through ED – Consult SI ED who will assess and consults Cardiology triage physician for a bed on 6.1 (see details below). Cardiology manages as MRP on 6.1 and any needed subspecialists co–manage patients with them.
- Patients already admitted needing IMCU level care (most likely MTU HMU) – The resident or attending physician assesses the patient and the attending calls the triage Cardiologist for a bed on 6.1 and transfer (Cardiology manages as MRP on 6.1 and any needed subspecialists co–manage patients with them). See details below.
- Neurosurgery and Neurology IMCU level patients continue to be managed on 7.3 IMCU.

* Bed manager continues to coordinate bed and flow
Specific Pathways for Patients Requiring IMCU
(Guidance for Medicine SI, ED charge doc, MTU and HMU physicians and flow coordinator who would help navigate)

GI Bleeds:
- COVID suspect or COVID positive needing IMCU and acute GI bleed admitted to 3IMCU and GI/Surgery co-manages with IMCU team.
- Upper GI bleeds come through SI ED (+/-) involvement of GI for consultation. If IMCU is required for a high risk UGIB, the General Surgery team at the HI is consulted. The initial assessment and orders would be completed by the Medicine SI team after consultation to General Surgery prior to transfer to the IMCU. The SI service would work with the flow coordinator to help determine IMCU bed location. The surgical team would assume care of the patient as the most responsible physician (MRP) once the patient is transferred out of the ED. Once in the IMCU, Surgery will consult with Gastroenterology to determine the need/timing of endoscopy.
- High risk lower GI bleed in ED goes to General Surgery if IMCU needed. General Surgery works with flow and finds a bed. Surgery MRP and GI co-manages patient with Surgery if endoscopy is needed. If a high risk GI bleed in a patient who is already admitted, the admitting service consults Surgery for IMCU admission. Once in the IMCU, Surgery will consult with Gastroenterology to determine the need/timing of endoscopy. When IMCU care is no longer required, the patient will be transferred back to the original inpatient service.
- Non IMCU GI bleeds follow the usual pathway to HMU/General Surgery. COVID suspect or COVID positive go to the 8.3 COVID unit.

Urgent Acute Dialysis:
- All of the IMCUs at the HI are capable to run dialysis in any of their beds (one at a time).
- 6.1 has 2 dialysis rooms.
- 3 IMCU COVID can run 7 at the same time as long as there was enough staff.
- COVID suspect or COVID positive needing IMCU and acute dialysis admitted to 3IMCU with IMCU as MRP and Nephrology co-manages with IMCU there. Nephrology will notify 3IMCU if COVID dialysis patient coming.
- If a patient requires acute dialysis (AKI, poisonings, unstable chronic dialysis patient) from ED or another health care facility, both SI and Nephrology will be consulted. SI will function as MRP. If patient needs IMCU, SI works with flow coordinator to determine location of an IMCU bed. SI consults Cardiology triage physician for a bed on 6.1 (cardiology manages as MRP in 6.1 and Nephrology and any needed subspecialists co-manage patients with them). If 6.1 at capacity for dialysis patients review with Nephrology case by case.
- If already an inpatient consult Nephrology and Nephrology contacts triage cardiologist for bed on 6.1. Nephrology follows in 6.1 IMCU as consultant.
- Pure nephrology patients needing IMCU and acute dialysis (peritonitis, urgent dialysis access complications, i.e. de-clotting or urgent tunneled line exchange) may be admitted to 6B IMCU. These happen very infrequently and may come through the ED or from other hospitals. If in the ED, obtain SI and Nephrology consult. If from outside of the hospital, contact Nephrology directly.

*Dialysis patients in adjacent beds as much as possible for nursing needs.*
Medicine Transfers to 6.1 IMCU:

New admissions through ED:
- Medicine resident and Senior Internist will assess the patient in the ED.
- If patient would typically go to 3IMCU, the Medicine team will call the Triage Cardiologist.
- Medicine team in the ED will be responsible for developing the treatment plan, establishing goals of care and writing admission orders and notes before transfer to 6.1.
- Senior cardiology resident will not be involved in the admission process of these patients. But still can support the junior house staff once the patient is in 6.1.
- Junior house staff/Clinical Associate covering 6.1 will assess these patients when they arrive on the floor.

Transfer from another medicine floor:
- Junior medical resident and then subsequently senior medical resident will assess the patient and then discuss this with the attending staff (Senior Internist) covering the unit.
- If the transfer is required, then attending staff (Senior Internist) covering the unit will call the triage cardiologist to discuss the patient.
- Triage Cardiologist will then inform the Cardiology senior resident and the charge nurse on 6.1 IMCU.
- Transfer orders, treatment plan, goals of care and transfer note will be completed by the Medical team before transfer to 6.1.
- Junior house staff/Clinical Associate covering 6.1 will assess these patients when they arrive on the floor and seek senior cardiology resident help if required.
- Cardiology attending on 6.1 will be the MRP for these patients and will consult other subspecialties as required for appropriate patient management.

Discharges form 6.1 IMCU:
- Once declassed, these patients will be transferred to a Medicine floor (MTU or HMU) for discharge after discussion with the MTU attending.
- If the patient gets discharged from 6.1 then the follow up will be arranged with the most relevant subspecialty.