Direction médicale et des services professionnels

Emergency Teams' Summary - Règle d'Utilisation des Ressources (RUR)

Starting September 2025, as mandated by Santé Québec, the MUHC will join other institutions by progressively adopting a new Règle d'Utilisation des Ressources for its adult Emergency Departments at the Glen site (Royal Victoria Hospital), Montreal General Hospital and Lachine Hospital. The goal is to improve the running of the EDs by providing a frame of reference for patient care and roles. The RUR:

1. **Standardizes** the approaches and practices for all clinicians working and providing consultations in the EDs.
2. **Gathers** all the information needed into a single document.
3. **Clarifies** some of the practices that were not being followed consistently and implements some new practices to improve patient management.

The RUR primarily affects the practices and responsibilities of emergency physicians and specialists. Nursing and administrative teams will also be affected, but to a limited extent.

Key points

- ✓ **These changes will lead to:**
  - Closer collaboration with consultants
  - Clear identification of the physician best suited to answer questions from staff and family – the Most Responsible Physician (MRP) for the patient
  - More frequent communications with MRPs
- ✓ **Ongoing effort is needed to:**
  - Use the ED resources solely for emergencies
  - Reduce the volume of consultations requested in specialized departments or necessary for patient referral
- ✓ **In order to ensure appropriate and timely medical direction, as well as to optimize patient care and reduce unnecessary delays:**
  - The consulting physician becomes the primary physician earlier in the patient's stay in the ED – **2 hours** after starting the consult.
    ***Only one consult with prise en charge (PEC) request per patient. Can and will include non-admitting services when patient likely does not need admission. Please see link to admission algorithm which should be followed.**
  - **Aim to start consults within 2 hours and complete within 4 hours of starting the consult (weekdays).**
    ***Human resource limitations and institutional constraints will be taken into account. The point of this is not to punish but to improve efficiency by working together and optimizing processes.**
  - **6 hours** after the start of the consult with PEC, a patient is considered **automatically admitted to the consulting service** but may stay in the ED if discharge is anticipated within the following **6 hours**.
    ***Discussion can and should occur between the consultant and the ED physician.**
  - **Move closer to the target average length of stay set by the management agreement, which is 16.7 hours.**
  - Observation until the next day awaiting a test is not permitted in the ED.
    ***Such patients need to have an admit request placed.**
  - **All consultations must be completed using OWord (access via Medurge).**
- ✓ **The RUR impacts the roles of both consultants and physicians, and its implementation will be closely monitored to track objectives and indicators.**
- ✓ **For any questions, please contact your manager.**

Limit to essential tests and consultations:

- All non-urgent examinations must be redirected to the appropriate outpatient department:
  - outpatient time slots reserved for semi-urgent consultations
  - referral to accueil clinique for patients meeting the criteria
  - return to the emergency department or clinic the following day, if necessary.
- If a patient is awaiting a specialist, the emergency physician should only become involved at the nurses' request.

Responsibilities and care:

- Specialists are required to take charge of patients **2 hours** after the start of the consultation with 'prise en charge', unless they notify the emergency physician otherwise.
- If a patient under the care of a specialist presents an acute complication, the emergency physician must intervene until the specialist arrives and is able to take over.
- For patients accepted by a specialist, the emergency physician is responsible for the decision to call the specialist between **midnight** and **7:00**.

When an MUHC physician refers patients to the ED:

- If a patient's condition is stable, prioritize outpatient services over the ED.
- The ED MD must be informed of all patients being sent to the ED.
- If diagnostic tests such as a CT or US or MRI is required, the referring physician must make the arrangements.

When another hospital requests an urgent consultation from an MUHC specialist:

- MUHC specialists will be alerted when a patient they accept from elsewhere arrives.
- The use of outpatient clinics and ambulatory care units is preferred when an admission is not deemed necessary.
- In general, inpatients from other hospitals are to be transferred to inpatient beds and bypass the ED.
- Patients from Northern Quebec are always accepted. Avoiding a transfer through the emergency department, when possible, is preferable.
- For more details, see the Transfer Policy in Appendix 4.

When a patient is accepted by a consultant service to the MUHC ED from another hospital:

- This must be communicated to the emergency physician (x32723 at the RVH and x43012 at the MGH)
- Patients should not be accepted to arrive after hours unless they need to be seen after hours because of their clinical state, in which case the consultant will be expected to see them whenever they arrive.
- Once the patient's care at the MUHC is completed, the consulting physician arranges for the return to the original hospital and communicates the medical plan.

When being asked to provide a consult in the ED, the following apply:

- A significant change is that the consulting physician, if asked for a consult with prise en charge, becomes the patient's most responsible physician and takes over the care plan **2 hours** after the consult is started. This includes ordering all necessary tests, discharging or admitting the patient. The consultant shall speak with the emergency physician if they feel that they are not the appropriate service.
- If a patient requires hospitalisation and the consulting physician cannot offer hospitalization, the consulting physician is expected to organize the hospitalisation by communicating directly with the appropriate service.
- Weekdays consults should start within **2 hours** and completed within the following **4 hours**. Exceptions: critical care patients and consults requested until the next morning.
- All consults placed between **8:00 and 18:00** are expected to be done the same day, and after hours will depend on the necessity because of clinical state or bed situation. The ED physician will determine when a consultant who is not in house needs to come in after hours.
- A patient should not be kept in ED overnight awaiting a consult if there is a bed available on the ward. The ED physician will communicate with the consultant to organize the admission. All consults requested but not done the night before are expected to be completed by **10:00** the following day.
- Consultants are expected to enter all tests and medications for their patients. Just writing recommendations in a consult reply causes significant delays.

When a patient needs intensive care:

- Consultation completion target is **2 hours**.
- Joint care occurs while the patient is in the ED, transfer of care takes place when the patient enters the ICU.
- If there are not enough ICU beds, it is the intensivist's responsibility to find a centre that can accommodate the patient using the *Centre d'optimisation - Occupation des lits de soins intensifs* (COOLSI).

When a patient must transit temporarily through the ED:

- The consultant must request the prior agreement of the ED physician.

When a patient returns to the ED within 48 hours of discharge from an inpatient unit or procedure:

- If the medical problem appears to be related to his or her recent surgery or procedure, a nurse or an administrative agent will notify the consulting physician who hospitalised or performed the procedure on the patient, who must see the patient.
- If it is not clear whether the medical problem is related, the patient will be assessed by the ED physician, who will decide whether the specialist should be called in for consultation.

Criteria for cardiac monitoring:

- The decision to place a patient on a cardiac monitor will be based on objective criteria outlined in the Emergency Medicine Department's guidelines for cardiac monitor use (Summary - Appropriate Use of Cardiac Monitoring in the Emergency Department, unless the physician deems it necessary to make an exception.

All documents (notes, orders, prescriptions, medications) must be in the electronic format available (either Oacis or Medurge):

- Consults must be documented in OWord accessed from Medurge, rather than Oacis.
- Medication prescriptions must be entered in Medurge.
- Verbal prescriptions are only accepted in emergencies or if the consultant is not present.
- Paper format must not be used, unless the option of prescribing or documenting is not available in electronic format (temporarily or permanently).

Read the Règle d'utilisation des ressources ED–Adult.