SUBJECT	RULES FOR THE USE OF EMERGENCY ROOM RESOURCES AT THE MCGILL UNIVERSITY HEALTH CENTRE (MUHC)

RESOURCE UTILIZATION RULE

SUBJECT:	RULES FOR THE USE OF ADULT EMERGENCY DEPARTMENT RESOURCES McGill University Health Centre (MUHC)		
ADDRESSEES:	All paramedical and medical staff, including MUHC physicians, dentists and pharmacists practicing or interacting with an MUHC Emergency Department		
ISSUED BY:	Medical and Professional Services Department		
APPROVED BY THE BOARD:		**RESOLUTIONS OF THE BOARD Nº:**	
REVISION DATE:			

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1 PURPOSE

The Emergency Departments of the McGill University Health Centre (MUHC) provide, at all times, the quality care and services required by people with urgent health problems who consult in them. They are an important part of the public healthcare system, offering 24/7 access to resources dedicated to the diagnosis and treatment of urgent and unforeseen health problems. They also provide an ultimate safety net for all MUHC patients.

Emergency department services include prioritization, stabilization, assessment, investigation and treatment, all with a view to rapid orientation. Rapid orientation means further consultation, discharge, hospitalization or transfer (targeted timeframe: average LOS of 12 hours if hospitalized, or 8 hours otherwise). It is a multidisciplinary resource, shared by a number of medical departments, staffed by a multidisciplinary team including emergency physicians, consulting physicians, nurses, pharmacists, orderlies, respiratory therapists, physiotherapists, social workers, other allied health workers, technicians and trainees in various disciplines.

Optimized Emergency Department management is an organizational priority for the MUHC. As an institution, the MUHC must have efficient Emergency Department management rules and mechanisms in place to ensure that access and quality of care are maintained, and that trajectories of users who consult in Emergency Departments are smooth and safe.

Access to emergency services is based on an integrated, hierarchical network organization where the user is in the right place at the right time. The vision of the Emergency Department is part of a continuum of care. Its mission is complementary to that of the network's other components (primary care, ambulatory care, hospital and post-hospital care).

The responsibility for timely access to urgent health problems is shared by the Emergency Department, the hospital community and the front line of the health care system. This access is influenced by the condition and clinical complexity required to address the urgent health problem. In order to optimize the use of Emergency Department within limited resources, it is essential to ensure that the right patients are in the right place at the right time to receive the appropriate care required by their biopsychosocial condition.

This Resource Utilization Rule (RUR) has been written to define the rules and mechanisms for the optimal use of the MUHC's Emergency Departments.

This RUR applies to all physicians, professionals and other stakeholders who work or interact with the MUHC Emergency Departments, at the level of the MUHC Department of Emergency Medicine. It establishes the rules for providing users with quality, safe care in the right place at the right time, as well as ensuring operational efficiency and accessibility, by specifying the roles and responsibilities of each stakeholder. Finally, it also specifies the administrative penalties for non-compliance with these rules.

The timelines outlined in the RUR may not always be met due to factors such as patient volumes, case acuity, staffing levels, and resource availability, whether at the MUHC or externally. These circumstances will always be carefully considered before any administrative sanctions are applied.

2 DEFINITIONS

In this document, the following words have the meanings indicated:

CA: Cardiopulmonary arrest

AIC: Assistant head nurse or assistant head nurse

DMSP: Directeur médical et des services professionnels (fr) – currently known as DMSP but also referred to as DSP or DPS

ALOS: Average length of stay

CEO: Chairman and Chief Executive Officer

MRP: Main responsible physician

NSA: Niveau de soins alternatifs (fr): Alternative levels of care, meaning: rehab, home care, CHSLD etc

PEC: Prise en charge (fr): assume main responsibility for the patient's care

RUR: Resource utilization rule

Medurge : Electronic system used in Emergency Departments; the term can be substituted by an other electronic system, where applicable.

Please note that "emergency physician", "consulting physician", "user" and "patient" is indicated in the text in the masculine gender, but refers to any gender, specified or undifferentiated. The term "chief" means the chief or delegate. The term "consultant" includes his delegate (e.g. resident).

3 LEGAL FRAMEWORK

This RUR is adopted in accordance with:

- The law to make the health and social services system more efficient (LGSSSS) (2023 chapter 34);
- The health services and social services act [R.S.Q., c. S-4.2] (LSSSS) and its regulations insofar as they are compatible with the above-mentioned Act;
- By-laws of the Council of Physicians, Dentists, Pharmacists and mid-wives of the MUHC (CMDPSF);
- Laws and regulations of the Collège des Médecins du Québec;
- Laws and regulations of the Ordre des infirmiers et infirmières du Québec;
- The laws and regulations of the other professional orders concerned;

Any provision of the LGSSSS aimed at making the health and social services system more efficient and the LSSSS or the aforementioned regulations apply, where applicable. In the event of any inconsistency, these laws and regulations take precedence over the present RUR.

The present RUR also takes precedence, in the event of incompatibility, over other duly adopted other MUHC departments or services regulations.

It should be noted that the rules and principles of the continuum of care in trauma, stroke, cardiac care (STEMI) and any other future directives with the same goals or constraints, notably the absence of right of refusal and emergency-to-emergency transfer, are established at the provincial level for a specifically defined clientele and take precedence. The “appartenance” rules adopted by the DMSP table remain applicable.

4 GUIDING PRINCIPLES

The RUR was drawn up by the ED leadership with the support and approval of the DMSP. This RUR is based on the following guiding principles:

- Promote accessibility, quality and relevance of care and services;
- Respect the mission of the Emergency Department, which is to provide each person who presents with an urgent health problem with the quality care and services required by his or her condition, at all times, using a patient-centered approach (resuscitation, initial stabilizing evaluation, treatment) and a rapid orientation: consultation, hospitalization, transfer or discharge;
- Achieve the performance and efficiency objectives expected by the public and expressed in ministerial directives and expectations;
- Promote harmony and complementarity amongst staff working in the EDs;
- Working in harmony with our regional partners.

5 SCOPE OF APPLICATION

This RUR applies directly to all physicians, from all departments, and affects all professionals and other stakeholders who work in or interact in one or more MUHC Emergency Departments.

6 RUR

6.1 TRIAGE

All emergency patients must be triaged by a nurse using an approved triage protocol. Depending on the outcome of the triage, the patient will be assigned a priority rating and will be:

1. Redirected to an external or internal resource;

OR

2. Directed to (within the ED):
   a. the waiting room
   b. the flex zone
   c. the stretcher area
   d. the stretcher overcapacity area
   e. the resuscitation area

The decision to perform cardiac monitoring prior to medical assessment is made by the triage nurse with guidance from the nurse in charge, when necessary, based on objective criteria (Outil d'aide à la décision - Utilisation judicieuse du monitorage cardiaque à l'urgence). Similarly, nurses may carry out examinations or procedures provided for in collective orders, where applicable, prior to the medical evaluation.

When the wait time to see the physician exceeds the recommended guidelines for the priority assigned to the patient, the patient's condition must be reassessed by the triage/pre-triage nurse or the nursing assistant assigned to collective orders, in collaboration with the ambulatory nurse or bedside nurse. Following this reassessment, the nurse may review the priority rating, redirect the patient according to the same principles as the initial triage, or ask the patient be brought to a room to be seen by a physician more rapidly (if the patient's condition requires it or if the patient's waiting time is deemed excessive compared with other waiting patients).

6.2 INITIAL MEDICAL "PRISE EN CHARGE" (PEC)

6.2.1 USER CONSULTING WITHOUT MEDICAL REFERRAL

All users who consult on an ambulatory basis or who arrive by ambulance, without referral, will be assessed by emergency physician, according to the priority assigned during triage, unless redirected to another resource.

6.2.2 USER REFERRED BY A PHYSICIAN WHO IS A MEMBER OF THE CMDPSF OF THE MUHC

When a patient is referred to the Emergency Department by a physician who is a member of the MUHC's CMDPSF who will be the managing service, the appropriate service will be called upon the user's arrival according to the triage procedure. It is the referring physician's responsibility to inform the consultant of the urgency of the medical condition, and of any important information that may facilitate the assessment process.

The emergency physician will carry out an initial assessment of the patient before proceeding with formally requesting the consultation. Care will be transferred to the consultant once they have seen the patient. The ED physician is expected to stay involved if the patient is unstable. The patient should be co-managed based on the principle of doing what is best for the patient. The ED physician must be made aware of any patient being transferred to the department.

The consulting physician must be available, whenever possible, when the patient arrives at the Emergency Department, and will take charge of the patient between 08:00 and 18h; if the patient arrives between 18h and 08:00, the consultant must see the patient at or before 08:00; the consult should be completed by 10:00. However, in the case of an unstable patient, the consultant physician must be present at any time, and may ask his colleague in the Emergency Department for simultaneous care.

Of note, one goal of the RUR is to support ED and hospital fluidity. Therefore after-hours consultation priority will be given to patients for whom being seen will make a difference to hospital flow, ie if there is a bed available on the ward the expectation will be that a disposition decision will not wait until the morning, which will keep the patient in the ED unnecessarily for 12+ hours. The emergency physician and the consultant can decide to discuss the case by phone and determine disposition, but the disposition decision should not be delayed until morning if there is an available bed. The ED physician will determine which consults need to be done after hours and will communicate with the consultant.

Referrals to the ED should be limited to patients who need to be seen in the ED. Services should attempt to take advantage of outpatient resources available such as rapid access clinics and day hospitals when possible, to avoid using the Emergency Department when not needed.

Patients should not be sent to the Emergency Department to speed up tests, consultations, preop work-ups or minor procedures unless the patient's condition requires it. In the event of an urgent specialized radiological investigation (ultrasound usually not available after 15 h or MRI), the referring physician must enter the requisition and organize the test (speak to radiology) before contacting the emergency physician.

If a patient is not previously expected by the specialist but comes with a request for a specialist consultation, the emergency physician will assess the patient's condition and decide whether the patient should be seen by the specialist as an emergency or as an outpatient.

6.2.3 INTER-HOSPITAL TRANSFERS

Without precluding any responsibility on the part of other caregivers, responsibility for the safety of the user during inter-hospital transfers lies with the physician at the sending facility. Priority should be given to the use of outpatient clinics and day hospitals for the assessment of stable and ambulatory users.

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.

In such cases the consultant becomes responsible for the patient once they are seen by the consultant. If the patient arrives between midnight and 8am, the consultant is expected to see the patient and complete the consult before 10am. Emergency physicians may be called in if the user is unstable on arrival and the consultant/treatment team is unavailable. They can also be called in by the consultant for simultaneous care.

An inter-hospital transfer can be accepted by a specialist if the patient is in another emergency (i.e. not admitted). If the patient is likely to need hospitalization, his arrival must be communicated to the coordinator responsible for hospital bed management. Ideally, such patients should go directly to an in-patient bed. Users who become unstable during transfer will be referred to the Emergency Department for stabilization. The emergency physician must be made aware of any accepted transfers.

Unstable patients should not be accepted to the ED except in exceptional circumstances. In general they should be stabilized before sending or, should they remain unstable, they should be admitted to the sending centre's ICU and transferred from there to the MUHC (or other per COOLSI) ICU.

For in-patient transfers, see section 6.6

An inter-hospital transfer may be accepted by an emergency physician in his or her name, for example, when the referral center's technical facilities or expertise do not allow investigation to be completed. (E.g. far North) without validating with the MUHC specialist. The emergency physician will then assess and direct the patient as required by his condition.

The Emergency physician also accepts transfers under the "appartenance" rules.

In the event that a patient is accepted by the radiologist for intervention and the patient has to remain due to a complication, the radiologist must contact the appropriate specialist and then the emergency physician before sending the patient to the Emergency Department. The procedure in point 6.2.2 then applies. This does not apply if the patient is unstable.

The use of the Emergency Department as a pure transit area is to be avoided.

Inpatients from other institutions should not be sent to the Emergency Department; rather, they should be transferred to an inpatient bed at the MUHC, except in exceptional circumstances.

6.2.4 POST-PROCEDURE PERIOD

Any patient presenting within 2 days with a problem that appears to be related to the procedure will be contacted by the triage nurse and asked to see the patient if during regular hours, and after hours if the patient requires urgent intervention. If more than 2 days have elapsed or if the presenting complaint may not be related to the procedure, the emergency physician will see the patient and determine whether the service needs to be involved.

In the event of a life-threatening emergency, significant pain, instability or an unrelated reason, the emergency physician will ensure initial management and involve the relevant consultants as required.

Services with daily or frequent outpatient treatment (e.g. dialysis, hemato-oncology, radiotherapy) are excluded. They will be assessed by the emergency physician primarily who will determine which service(s) to involve.

6.3 THE EMERGENCY PHYSICIAN: ROLE AND RESPONSIBLITIES

6.3.1 PRESENCE

The by-laws of the MUHC Emergency Department set out the details for ensuring continuous coverage of the various MUHC Emergency Departments, the number of physicians on duty, the publication of the list, the rules for replacement in the event of non-availability, and the mechanism for recalling physicians not on duty.

At least one emergency physician must be present in each facility, 24 hours a day, 7 days a week. An emergency physician may not leave the facility without ensuring that at least one other emergency physician is present in the ED. This obligation cannot be delegated to a resident physician. To ensure minimal coverage, the Department of Emergency Medicine must have an action plan, including the use of a recall list.

Each physician is responsible for making or coordinating a replacement for a shift he is assigned to on the official work schedule, regardless of the time slot involved. Emergency physicians are responsible for finding a replacement themselves, and should contact the chief only in the event of incapacity. The physician covering Code Orange/on-call on the day of the problem shift will cover for the physician who is unable to attend or complete his or her shift unless another physician agrees to take the shift. If the shift is more than 7 days away, the physician covering Code Orange is not required to work it. The department chief may adjust the schedule of the physicians who were scheduled to work (shift substitution on the same day) on the problematic day, in order to ensure adequate and safe coverage of the Emergency Department. In the event of overcapacity, the ED secretary will send a message to the group informing them of the situation and asking for volunteers to come in and help.

The Code Orange physician must be reachable at all times between 07:00 on the day he or she begins Code Orange coverage and 06:59:59 on the following day. He or she must be reachable within a reasonable time. He or she must be on site within 1 hour if necessary.

6.3.2 SECTOR ASSIGNEMENT

When there are several emergency physicians on duty, each is assigned to a particular sector, in the interests of efficiency and effectiveness. However, as soon as they are able, they are expected to help with patient PEC in other sectors, in particular in the ambulatory sector.

6.3.3 PATIENT CARE RESPONSIBILITIES

The emergency physician is the attending physician responsible for all users under his care, and for all residents and students under his supervision. He is also responsible for users transferred to him by the physicians preceding him in the Emergency Department.

The emergency physician remains the attending physician until the patient is discharged from the ED, is taken in charge by another attending physician, (either another emergency physician or specialist), or a request for admission accepted by telephone with the admitting physician.

The emergency physician is not the most responsible physician for a patient admitted to a specialty, nor for a patient under the care of (prise en charge by) a consulting physician as part of a request for consultation and management. The emergency physician will, however, assist in urgent situations until the hospitalist/specialist in charge of the patient arrives in the Emergency Department, and care can safely be transferred.

In the event that a user under the care of or accepted by a consultant does not require the tertiary care provided at the MUHC (for which he or she was transferred), and must be returned to the referral center after assessment by the consultant, it is the accepting consultant's responsibility to contact the referring center to advise the physician at the referring center and transfer the care verbally and in writing.

6.3.4 PATIENT ASSESSMENT and SPECIALIST CONSULTATION

With the exception of users redirected from triage (section **6.1**) and those whom consulting physicians are called upon to see and manage directly (see section **6.2**), the emergency physician must diligently assess all users presenting to the Emergency Department, in an order that takes into account the priority rating assigned to triage or reassessment. When several emergency physicians are working simultaneously in the Emergency Department, they assume this responsibility collectively; regardless of the user's location in the Emergency Department (see section **6.3.2**). It should be noted that some patients with excessive waiting times may be prioritized for assessment by the emergency physician, despite their initial priority assigned to triage.

For the patients under his or her care, the emergency physician must, in particular, but not exclusively, establish a differential diagnosis in line with the reason for consultation, and put into action an appropriate investigation and treatment plan.

In order to maintain accessibility to the Emergency Department and to be able to respond to future patient needs, the stabilization, evaluation, investigation and treatment must be carried out with a view to rapid medical disposition: discharge, request for consultation, hospitalization or transfer.

It is the responsibility of the emergency physician to consult sparingly and appropriately based on the needs of the patient and the MUHC admission algorithm. The consult with prise en charge should only be asked of one service according to the admission algorithm. Open communication between the ED

physician and the consultants is expected regarding the most appropriate service to prise en charge the patient.

Among other things, any examination or care that does not require the ED's technical resources and can be performed outside the ED acute care episode must be performed outside the ED. Any non-urgent examination must be redirected to the appropriate resource. Convenience (“since the patient is already here”) is not a valid reason for additional work-up, testing or consults.

As the MUHC's Emergency Departments are university academic environments, the emergency physician must include students and residents in his or her interaction with users, and give them an appropriate place, under supervision.

6.3.5 RESPONSIBILITIES TOWARDS USERS FOR WHOM HE OR SHE IS NOT THE ATTENDING PHYSICIAN

As detailed in section **6.3.3**, the ED physician is not most responsible physician for all ED users.

However, if an Emergency Department patient, under the care of a consulting physician, presents with an acute complication that puts his/her life or safety at risk, the Emergency Department physician must intervene and take care of the acute condition until the most responsible physician arrives (as soon as possible). On arrival, the attending physician assumes responsibility for the patient's care and further treatment and investigations, though they can ask that the ED physician aid in the care of the patient. The principle of doing what is best for the patient is to be respected.

The attending physician must be available on short notice, 24 hours a day, every day, with a maximum delay of 1 hour to be on site if necessary. If a shorter period is stipulated in the regulations of the department or service concerned, the latter takes precedence.

6.3.6 PRESCRIPTION OF RADIOLOGICAL EXAMINATIONS, LABORATORY, MEDICATIONS AND OTHERS

The emergency physician is responsible for following up on the orders, analyses and imaging examinations he or she has ordered and prescribed for a patient, including examinations ordered as part of a collective order.

Emergency physicians must complete radiology orders with information relevant to their interpretation, in order to ensure safe follow-up. Documentation of the interpretation of plain radiographs by the emergency physician in the PACS system is an encouraged method for quality assurance.

All prescriptions and orders must be made in the electronic format available (either Oasis or Medurge, as applicable).

Please note that medication prescriptions must be entered in Medurge. No prescriptions in any other format (i.e. paper) will be accepted. Verbal prescriptions are accepted only in resuscitations or if the physician is not present or free to enter the medication. (See MUHC policy on verbal prescriptions)

Unless the option of prescribing or documenting is not available in electronic format (temporarily or permanently), users must not use paper format.

All of the above applies to consulting physicians as well.

6.3.7 CARDIAC MONITORING

The emergency physician and other physicians must comply with the objective criteria: INESSS Rapport en soutien - Utilisation judicieuse des moniteurs cardiaques à l'urgence for the use of cardiac monitors in the Department of Emergency Medicine, unless exceptions justify it in the physician's opinion.

6.3.8 END-OF-SHIFT TRANSFERS

Emergency physicians are responsible for ensuring all patients in their care are accepted by another physician at the end of their shift. In the case of transfer to another ED physician, this is done one case at a time. The use of the sign over tool in Medurge is strongly encouraged.

For consultants, this should be done during the shift or at the end, following the rules described in section 6.5. Under no circumstances should a transfer of care occur without the receiving physician's acknowledgment. The correct MRP must be identified in Medurge at all times.

In preparation for the transfer, the attending emergency physician must prescribe all relevant medications, consultations and other orders, and manage his patients' "appartenances" (including requests, contacting the receiving center during the hours 8h - 18h). In the absence of a coordinator, he/she must also contact the receiving center if there is an inappropriate refusal.

To ensure proper handover, the ED physician must be present at the start of his or her scheduled shift; in the event of incapacity, he or she must notify the physician he will be replacing directly. Frequent lateness will necessitate meetings with the emergency manager or his delegate and may result in disciplinary action (Appendix 2).

6.3.9 ORIENTATION DECISION-MAKING

To avoid prolonged stays, and in line with the principles of the "Guide de Gestion des urgences" (MSSS), all emergency physicians are encouraged to aim for a prise en charge duration by the emergency physician of less than 6 hours before a decision (consultation, admission or discharge) is made. As soon as they have all the necessary information, physicians must ensure the orientation of users they have assessed and taken charge of during their shift: admit, discharge or request a consultation in specialized medicine.

While ensuring an appropriate assessment and aiming for the safety of patient care, only a minimum number of users should be transferred to the next emergency physician.

It is expected that if all the information required for a disposition decision is available at the time of shift change, the outgoing emergency physician finalize the patient's disposition and avoid delegating care to the incoming emergency physician.

Physician-coordinators, when available, can help with difficult dispositions (admissions, discharges, transfers), but reasonable efforts must be made by the emergency physician before involving them.

6.4 CONSULTATIONS

Consultants commit to completing their consultations (discharge, admission, direct discussion with another department to formally involve them in the patient's care) in 4 hours or less (from starting the consult) from 8:00 to 18:00. All consults put in by 18:00 are expected to be seen the same evening. These slots are extended if the hospital's overcapacity plan is activated and if there is a bed available or the patient may be discharged, ie it will make a difference to the ED's volume of patients. Also, consultants should come in to see their patients who are unstable or who need urgent interventions performed by that specialty.

The MUHC's surgical services are committed to completing their consultations within the timeframes described in this document, even when they are in the operating room, as long as it is safe for a team member to be absent from surgery for a short period of time.

As these decision times are averages, it is possible and agreed they may not be respected for a particular user, or for all users seen on a shift, given the manpower issues and volume of consults, which will be taken into account. However, it is expected that the physicians will meet these targets by averaging his or her turnaround times over an extended period of time.

Consulting services are responsible for making sure that there is someone to answer calls or informing locating that they are temporarily unavailable (such as in the OR). For all consultations the service is expected to answer the call within 5 minutes. If there is no answer after 15 minutes, the unit coordinator will try again. Thereafter every 15 minutes there will be an escalation to who is paged, ie medical student then resident then fellow then staff then division head then DPS on call.

6.5 THE CONSULTING PHYSICIAN

6.5.1 CONSULTATION REQUESTS

The physician requesting another physician for consultation must complete the request in Medurge and include the clinical information necessary to prioritize the consultation, explaining and justifying the consultation. (i.e. "as discussed" as the only justification is not acceptable). In order maintain accessibility to the Emergency Department and avoid emergency overcrowding, **any consultation for a condition not requiring referral during the emergency visit must be arranged outside the emergency visit, in a more appropriate environment.** Please note that, statistically, each consult will at least double the LOS of the patient.

Prior to the consultation, it is strongly encouraged to obtain reasonable baseline tests to enable the consultant to complete rapidly his assessment. Additional tests deemed necessary to orient the patient during the emergency stay are the responsibility of the consulting physician (according to his/her field of expertise)

In all MUHC EDs, consultations for patients who, in the opinion of the ED physician are unstable or at risk of rapid deterioration must be carried out as quickly as possible, 24 hours a day, every day. Consult requests for critically ill patients or those at risk of rapid deterioration are to be communicated directly from the emergency physician to the consultant. All consultations must be completed using OWORD software, facilitating efficient and secure digital communication between healthcare professionals and Emergency Department users. The consultation status is automatically updated in Medurge via interface with OWORD if the status preliminary or final is used. Once created via Medurge, a document can be visualized via Oacis and updated when needed.

At all times, the emergency physician and consultants must aim to minimize requests for consultations, by referring consultations that do not need to be carried out during the user's stay in the Emergency Department, in particular by:

1. The use of reserved outpatient slots for semi-urgent consultations;
2. Referral to rapid access clinics for users meeting the criteria;
3. Referral to the day hospital (RVH or MGH)
4. Refer the patient to GP or walk-in clinics to arrange other interventions
5. Consult regular outpatient clinics

A request for consultation cannot be refused by the medical service requested for consultation. If it is considered that the request for consultation is ill founded, or that its type or timeframe could be different from that indicated, there must be a collegial discussion to this effect between the physician requested for consultation and the physician who requested the consultation. **Only the physician in charge of the patient can modify or cancel the consultation.** If an attending physician cancels a consultation requested by another physician, the details justifying the cancellation must be entered in Medurge (and in the medical note). Please note that consultations must not be refused or delayed due to quotas.

6.5.2 TYPES OF CONSULTATIONS

When requesting a consultation, physicians, including emergency physicians, must indicate the type of consultation requested:

1. **Consultation (without further specification):** the physician requesting this type of consultation remains the user's attending physician. He or she only wishes to obtain the consultant's opinion on the course of action to be taken in terms of investigation or treatment, or his opinion on the diagnosis. The consultant physician should order any tests or treatments they feel are pertinent and discuss them with the emergency physician, as well as consulting services they deem necessary. Written notes with

recommendations that the ED physician is unaware of can significantly delay orders being done and prolong length of stay.

The consultant physician can and should make recommendations about these patients' dispositions. They remain involved in the care of the patient until they formally sign off.

2. **Consultation and PEC (prise en charge):** the physician requesting this type of consultation wants the physician in the specialty requested for consultation to become the user's most responsible physician. This can be for non-admitting services if the patient is likely to be discharged. If a non-admitting service is consulted and they decide that the patient should be admitted, they should consult the appropriate admitting service.

When requested by an emergency physician, this transfer of responsibility, (whereby the consulting physician becomes the user's attending physician and the physician who initially requested the consultation withdraws from the case), occurs two 2 hours after the consultation has begun.

If the consulting physician assesses a patient and concludes that the referral is not within his of expertise, he may discuss the matter collegially with the emergency physician for joint redirection to another consultant or back to the emergency physician. This must be done within 2 hours of the start of the consultation.

This rule applies only if the consult is requested by an emergency physician. Otherwise, the transfer of care occurs only when it has been explicitly agreed to between the two services. In case of disagreement, the medical coordinator or DMSP can arbitrate.

When the consulting physician becomes the user's attending physician (MRP), he or she is responsible for the rest of the patient’s trajectory (unless transferred to another service). Under no circumstances may a patient under the care of a consulting physician be released from his care if the patient's condition prevents him or her from leaving the Emergency Department, for whatever reason (e.g. unsuitable living environment, other medical issues, etc.). Just as a patient cannot be un-admitted unless discharged, a consultant may not un-PEC a patient for whom they are the MRP. If the patient needs to be admitted, then it is up to the consultant to involve an admitting service. The consultant remains the MRP until taken over by another service.

Although several consultations may be requested in different specialties for the same user, only one should be of the "Consultation with PEC” type, due to the nature of the consultation. As a general rule, the need to involve other consultants is left to the person being asked to take charge.

It is essential that all teams involved ensure that unnecessary hospitalizations are avoided, and that users who can be adequately cared for by out-of-hospital resources are properly oriented.

6.6 THE CONSULTING PHYSICIANS

6.6.1 EMERGENCY DEPARTMENT COVERAGE

All medical departments called upon to perform Emergency Department consultations must plan and make known in advance the schedule of physicians in their department assigned to cover Emergency Departments. The schedule must provide for coverage 24 hours a day, every day of year. It is the responsibility of each department to ensure that this coverage is maintained, and that any changes are made known to locating service.

A physician recall procedure must be in effect at all times for each department to manage any potential crisis such as an unexpected absence or a Code Orange. The mechanisms for drawing up and using this list are determined by each service and are set out in their regulations.

6.6.2 CONSULTATION TIMELINES

All consults requested before 18 h are expected to be done the same day. Prior to the consultation, the emergency physician should obtain reasonable baseline tests to enable the consultant to complete rapidly his assessment. Additional tests deemed necessary to orient the patient during the emergency stay should be ordered by the consulting physician (according to his/her field of expertise). As noted above, the principle of not leaving patients in the ED unnecessarily is to be followed. Therefore, consultants are expected to come to disposition decisions on patients after hours, especially if there are inpatient beds available. The emergency physician will decide whether a consult should be done after hours and will communicate this with the consultant physician.

According to the MSSS Guide de gestion des urgences, the consultation should be completed within 4 hours of starting.

Consultations for patients who, in the opinion of the ED physician, are unstable or at risk of rapid deterioration, must be carried out as quickly as possible, 24 hours a day, every day. These consultation requests require the emergency physician to communicate personally with the consulting physician or the consulting physician's resident physician. For critically ill patients it is expected that the consultation be started within one hour.

If a consulting service’s capacity to provide consultation and care services in a timely manner is repeatedly exceeded, the department concerned must help implement solutions to resolve the situation.

On weekends and public holidays, the number of consulting physicians per specialty is often lower, and they may cover more than one site. This makes it all the more important for the consultant to contact the emergency physician so that they can agree on the priority / delay to be applied to this consultation request.

After 18:00, the physician requesting a consultation to be carried out during the patient's stay in the Emergency Department will determine whether the consultation can wait until the following morning.

This does not apply to services that provide 24/7 on-site coverage. For after-hours consultations that do not need to be done the same night, the emergency physician can either:

1. Keep the patient overnight (if needed). nb the consultation is entered by the evening physician and the patient is not well known to the morning ED physician.
2. Ask the patient to return the next day in the ED or in clinic. This is the preferred option.

If the consultation needs to be done that night then the emergency physician needs to communicate this to the consultant.

When the request to carry out a consultation has been postponed until the morning, the consultation is expected to be finalized before 10:00.

Given the high volume of patients they serve and their impact on patient disposition, the Medical Imaging Department needs to work closely with the Emergency Department. This coverage discussed in **Appendix 1**.

For multidisciplinary professional services such as physiotherapy, social work and specialized addiction liaison, coverage is required until 16:00 every day. In the event of consults after 16:00, evening consultations must be prioritized for the following morning. Service agreements should also allow for outpatient assessments for these services whenever possible.

6.6.3 SERVICES WITHOUT HOSPITALIZATION PRIVILEGES

If the user's condition requires hospitalization, it is expected that the consulting physician who cannot offer hospitalization will arrange for the user's hospitalization by communicating directly with the appropriate service. This must be included within the time target mentioned above (4 hours, except for consultations postponed to the morning, which must be completed before 10:00 a.m.).

6.6.4 PATIENT ORIENTATION

A patient's stay in the Emergency Department must be as short as possible. (Average LOS 12 hours for admitted patients). Rapid decision-making must therefore be the norm; observation is only permitted in the ED when it can be included in the time allotted to complete the consultation. **Any patient being kept overnight for testing must be admitted to the service requesting the tests. Admit slips should be put in regardless of whether there is an available bed on the ward.**

Even when several consultations are required for the same patient, a maximum stay of 24 hours in the Emergency Department must be maintained and, consequently, a decision on possible admission must be made within this period.

Between 8:00 and 18:00, as a rule and when appropriate, a patient will be considered admitted 6 hours after the start of the consultation. If, at that time, a discharge is anticipated within the following hours (6 hours), the consultant may request that the patient remain in the Emergency Department (he/she will, however, have an "admitted" status).

Between 1800 and 0800, even if services are still encouraged to admit as appropriate, the rule does not apply.

As mentioned above, for services that do not admit, they must request a consultation for admission (when deemed necessary) within 4 hours of the start of the consultation. They must discuss the case with the appropriate service to enable the patient to have a request for admission within a total 6-hour period. No observations are permitted in the Emergency Department. Overnight stays when a bed is available and the ED is overcapacity is not permissible (refer to OC protocol).

Once admission has been requested, the patient must be directed as quickly as possible to the in-patient care unit, with the aim of meeting the MSSS targets, in particular an average delay of 30 minutes between the assignment of a bed and the user's departure from the Emergency Department. The availability of inpatient beds will necessarily impact the possibility of this goal being achieved.

As the decision and response times in this section are averages, (unless otherwise specified) it is possible and agreed that they may not be met for a particular user, or for all users seen on a shift. However, it is expected that these targets will be met over a longer period.

6.6.5 PATIENT REQUIRING INTENSIVE CARE

The availability of an intensive care bed (ICU or CCU) at the MUHC for a user coming from an MUHC Emergency Department and meeting the appropriate admission criteria must be ensured 7 days a week, 24 hours a day.

From the moment admission to a critical care unit is accepted by the intensivist on duty, the Emergency Department stay of the patient requiring this level of care must be limited in order to free up Emergency Department resources. Management of critically ill patients follows a model of joint care in the ED. Transfer of care to the intensivist occurs when the ICU physician accepts it or by default when the patient is physically transferred to the critical care unit. Management of these patients while in the ED follows the model of joint care.

For users requiring hospitalization in a critical care unit such as the coronary unit, or the intensive care unit, the target length of stay in the Emergency Department, once the patient is deemed appropriate for ICU, should be less than 2 hours. This 2-hour time limit should not be interpreted as a limit to the stabilization interventions required before transfer to a critical care unit, nor should it interfere with the ability of these units to care for users from non-emergency wards.

In the event that no ICU bed is available, the intensive care physician must assess the appropriateness of transferring via COOLSI and call COOLSI if appropriate and make the arrangements.

i. RETURN TO EMERGENCY PHYSICIAN FOR MANAGEMENT

When a request for consultation mentions “with PEC “, a decision to discharge by the consultant physician who is the MRP does not need to be reviewed or reassessed by the emergency physician before departure. Thus writing, "To be reviewed by the Emergency Department" or similar is generally inappropriate.

If the physician who took charge of the patient considers that special circumstances justify the ED physician becoming involved in the case again, or becoming the attending physician, he or she must agree verbally with the ED physician and obtain the latter's agreement. These situations should be the exception rather than the rule, and should be dealt with on a case-by-case, collaborative basis.

In the same way that some care can be deferred on an outpatient basis, the non-urgent problems of users should not be referred to the ED. If in his or her judgment, the physician who has taken charge of the patient feels it appropriate, he or she should refer the patient to his family physician or, if the patient has no family physician, to a walk-in clinic.

ii. CARDIAC MONITORING

The consulting physician must comply with the objective criteria for the use of cardiac monitors in the Department of Emergency Medicine (INESSS), unless exceptions justify it in the physician's opinion.

6.7 TRANSFER FROM ANOTHER ENVIRONMENT AND REQUEST FOR EXTERNAL CONSULTATION

6.7.1 FOR AN EMERGENCY PHYSICIAN

The emergency physician may accept transfers from other settings and requests for consultation on behalf of the Emergency Department for users whose diagnosis needs be clarified using the technical equipment available in the Emergency Department or with the expertise specific to emergency physicians. The transfer of such users to the Emergency Department is then deemed appropriate. This includes cases of “appartenance” and mandates specific to the MUHC.

On the other hand, if the patient requiring transfer is an inpatient at the referring center, the referring physician must be redirected by the emergency physician and advised to contact the physician on call for the specialty concerned. The emergency physician must not accept this type of transfer. All inpatients transferred go to the ward, not to the ED.

If a patient in a referring center requires intensive care, the physician in charge of intensive care at the MUHC should be contacted, and the patient should go directly to intensive care, avoiding a stay in the ED. If no intensive care beds are available, the referring center should use the COOLSI service to find a hospital that can take the patient directly to intensive care.

Should the consultants deem it necessary for the user to temporarily transit through the Emergency Department, the prior agreement of the Emergency Department physician is required.

Exceptions to this rule are users whose care trajectory is already the subject of a transfer agreement between different emergency services, including cases where a tertiary or specific mission is respected.

6.7.2 FOR A CONSULTANT PHYSICIAN

All consulting physicians must comply with the Procedure for the Transfer of Users between Institutions or Facilities for Admission to the MUHC (see Transfer Policy in Appendix 4).

Among other things, this procedure stipulates that when this concerns an admitted patient, such transfers must be made to an in-patient unit and not to a stretcher in the Emergency Department except in exceptional time-sensitive situations.

**** All cases requiring transfer to the ED must be approved by the Emergency Department physician.**

Any inter-hospital transfer of admitted patients accepted by a specialist must be communicated in advance to the coordinator responsible for hospital bed management. In cases where there are no beds available at a site, a discussion with the coordinator responsible for bed management will enable a decision to be taken either to admit the patient to the Emergency Department on behalf of the consulting physician, or to redirect the patient to another site better able to accept the transfer.

In addition, the use of outpatient clinics and ambulatory care units is to be preferred when an admission is not deemed necessary. If circumstances make it impossible to use these units, the user may be referred to the Emergency Department. A stay of 6 hours or more in the Emergency Department, must result in a request admission.

As mentioned above, when a transferred patient arrives, the physician in the specialty who has accepted the transfer will be notified of the patient's arrival by the triage nurse, and becomes responsible for the patient once he (the consultant) arrives in the Emergency Department. The physician who has accepted a transfer must be available promptly (within 1 hour) every day. **Patients should not be accepted in transfer after regular hours unless they need urgent assessment and intervention, in which case the accepting service will be expected to see at all hours.**

For all cases accepted by MUHC consultants, coordinating the patient's return with the referring center is the responsibility of the consultant who accepted the patient. (See also 6.2.3). Consultants should accept patients appropriate to them (rather than deferring to the ED physician to accept).

6.7.3 DOCUMENTATION

All consultations must be completed using OWORD software (accessed via Medurge), facilitating efficient and secure digital communication between healthcare professionals and Emergency Department users. The consultation status is automatically updated in Medurge via interface with OWORD if the status preliminary or final is used. Once created via Medurge, a document can be visualized via Oacis and updated when needed.

All prescriptions and orders must be made in the electronic format available (either Oacis or Medurge, where applicable). Medication prescriptions must be written in Medurge. No prescriptions in any other format (i.e. paper) will be accepted. Verbal prescriptions are accepted only in resuscitations or if the

physician is not physically present in the department (e.g. consultant). (See MUHC policy on verbal prescriptions). Tests are to be ordered under the name of the ordering physician unless discussed with another physician who agrees to order under their name.

Unless the option of prescribing or documenting is not available in electronic format (temporarily or permanently), users must use the digital format.

6.7.4 PATIENTS FROM THE FAR NORTH

The acceptance of patients from the Far North is an exception to certain rules: depending on needs, a hospitalized patient may be accepted on an emergency basis. Transfers from the north from native communities within our RUIS are to be accepted. As always, alternatives to the Emergency Department (clinic, remote follow-up, etc.) must be explored and transfers should be directed to the appropriate centre (ie MGH for psych and ortho).

6.8 AUTHORITY TO ADMIT DMSP

If necessary, the director or assistant director of professional services and medical affairs, the emergency coordinating physician (or, in his or her absence, the physician designated for this purpose) will determine to which service the patient will be admitted. For example, when 2 physicians of different specialties, although convinced of the need for hospitalization, cannot agree on who should be the attending physician, the DMSP, medical coordinator, or delegate.

7 ADMINISTRATIVE SANCTIONS

No administrative sanctions will be applied during the first three months following the implementation of the RUR

7.1 REVIEW OF AN INCIDENT OR DEVIATION FROM THE RUR

Each reported situation must be reviewed with rigor, fairness, and clarity. The analysis aims to distinguish between:

- Situations attributable to external factors or to a case of force majeure;
- Systemic or organizational shortcomings;
- Situations individually attributable to the professional concerned.

7.1.1 PRELIMINARY ASSESSMENT

The preliminary assessment is carried out by three individuals: the head of the relevant department or clinical unit, the service chief of the physician concerned, and the Director of Medical and Professional Services (DMSP) or their delegate.

Three areas are examined to contextualize the report:

a. **Exceptional Circumstance**
   - An unforeseeable event beyond the physician's control;
   - Technical or Logistical Failure;
   - Acute Overload or Systemic Crisis.

b. **Service Demand**
   - Volume and nature of consultations at the time of the incident;
   - Conflict with other clinical priorities;
   - Contextual clinical pressure.

c. **Service offer**
   - Actual presence and availability of medical staff;
   - Justified or unforeseen absences;
   - Actual capacity for coverage or replacement.

7.1.2 CONCLUSION

Following the analysis, one of the following three findings is determined:

a. Event beyond the physician's control
Finding: The physician did not have the means to mitigate the situation, which remained beyond their individual control.
Measure: None. The file is closed. A note may be recorded for organizational monitoring purposes.

b. Organizational problem
Finding: The inadequacy results from a structural shortcoming or a lack of planning.
Measure: Recommendation to department head or DMSP for corrective action (e.g. adjustment of schedules, staffing levels, processes).

c. Individual responsibility
Finding: The physician's behavior or omission constitutes non-compliance with the RUR, without acceptable justification.
Measure : Graduated sanction, according to the guidelines set out in the regulations of the Conseil des médecins, dentistes, pharmaciens et sages-femmes CMDPSF or the MUHC (see section 7.2).

7.1.3 PROCEDURE AND PROCEDURAL RIGHTS

a. Right to be heard
When relevant, the physician concerned is informed of the nature of the alleged misconduct and the facts of the case. If individual liability is considered, the physician has the right to be heard before any final decision is made, in accordance with the principles of natural justice and section 274 of the LGSSSS.

b. Documentation and traceability

- All decisions are recorded formally and with reasons;
- The conclusion and measures are officially transmitted to the physician concerned;
- In the event of a sanction, this is added to the physician professional file and forwarded to the CMDPSF Executive Committee for follow-up and clinical governance purposes.

7.1.4 CONFIDENTIALITY AND REPORTING

Exchanges, decisions and documents produced as part of this procedure are treated as confidential.

The DMSP ensures that the procedure complies with the *Loi sur la gouvernance du système de santé et des services sociaux (LGSSSS)*, the risk management policy, institutional obligations in terms of quality of care, and the fundamental rights of the professionals concerned.

7.2 ADMINISTRATIVE SANCTIONS: NON-COMPLIANCE WITH A SPECIFIC ELEMENT OF THE ED RUR

The process leading to administrative sanctions applies as follows:

- **1st intervention for non-compliance with the RUR (verbal warning):**
  1. When intervention becomes necessary due to non-compliance with the RUR, the intervening party must inform their immediate supervisor, who in turn informs the chief of the medical emergency service of the facility in question.
  2. The latter will determine whether to intervene directly with the non-compliant physician (if they are a member of their team); otherwise, the matter is referred to the chief of the non-compliant physician's service, who is responsible for issuing the initial verbal warning.
  3. If the non-compliant physician is the chief of the medical emergency service at the facility, the Chief of the Department of Emergency Medicine must be informed.
  4. If the non-compliant physician is the Chief of the Department of Emergency Medicine, the DMSP must be notified.
  5. The facility's emergency service chief, the department chief, or the DMSP, as applicable, will be the only person who may know whether previous interventions have occurred involving the same individual.

- **2nd intervention for non-compliance with the RUR (written warning):**
  1. When a second intervention becomes necessary due to non-compliance with the RUR, the chief of the medical emergency service at the site is informed.
  2. They will determine whether to intervene directly with the non-compliant physician (if the individual is one of their team members); otherwise, they will refer the matter to the physician's service chief, who will be responsible for issuing the second written warning and providing a copy to the Chief of the Department of Emergency Medicine; the Chief of the Department of Emergency Medicine will inform the Executive Committee of the Emergency Department of the nature of the RUR non-compliance, in a non-nominative manner, for the purpose of monitoring interventions related to RUR compliance.
  3. If the non-compliant physician is the chief of the medical emergency service at the facility, the department chief will be informed. If the non-compliant individual is the department chief, the **Directorate of Professional Services and Medical Affairs (DMSP)** will be informed and will issue the written warning.

- **3rd intervention for non-compliance with the RUR (written warning and response from the non-compliant) :**
  1. When a third intervention becomes necessary due to non-compliance with the RUR, a written notice is issued by the chief of the emergency medical service at the facility involved to the Chief of the Department of Emergency Medicine, who in turn notifies the DPSMA

responsible for emergency services.

2. A written notice is then issued to the non-compliant physician by the DMSP, summoning them to a meeting, accompanied by their service or department chief, as applicable, in order to present their version of the facts. A copy of this notice is also sent to the non-compliant physician's service chief, department chief, and the Chief of the Department of Emergency Medicine.
3. The non-compliant physician must submit a written response to the DMSP within 10 days of the meeting. The response must include an explanation of the situation, as well as a commitment to refrain from violating the relevant rule(s) again, if applicable.
4. If the non-compliant physician is the chief of the emergency medical service at the facility, the department chief will be informed. If the non-compliant individual is the department chief, the DPSMA will be informed.
5. The DMSP may, if applicable, impose an administrative sanction on the professional that limits or suspends their right to use the Emergency Department resources of the MUHC.
6. When such a sanction is imposed, the DMSP must inform the professional of the reasons on which the decision is based.
7. If the professional disagrees with the decision, they may contest it within 60 days of the date it was formally communicated, by filing an appeal with the Administrative Tribunal of Québec.
8. The DMSP must inform the CEO of the nature of the sanction imposed.

In the event that the non-compliant physician is a **medical resident**, the DMSP must inform the Education and Simulation Directorate of the non-compliance with the present RUR.

The resident will be met by the supervising physician to be reminded of the usage rule. As of the **second instance of non-compliance**, the Education and Simulation Directorate will be made aware of the situation, jointly with the supervisor, by the clinical service chief.

The Director of Education or their representative will determine whether to intervene directly with the non-compliant resident; if not, they will discuss the matter with the director of the resident's medical program, and a written notice will be issued.

8 RESPONSIBILITIES

8.1 DEPARTMENT MANAGER

Under the authority of the DMSP, the chiefs concerned have the following responsibilities:

- Ensure compliance with this RUR and inform the DMSP of any non-compliance by a physician or dentist;

- Where no department head is designated, the responsibilities referred to in this section are exercised by the DMSP.

1. CLINICAL DEPARTMENT MANAGER

Under the authority of the Head of Department, the Head of Department concerned must:

i. Ensure compliance with the present RUR at all times by all members of his department and consultants, or appoint a specific delegate to ensure this vigilance;
ii. Collaborate with the Head of Department in the application of administrative measures, as required.

2. MEMBERS OF DEPARTMENTS AND SERVICES

All members of the departments and services concerned by the present RUR must familiarize themselves with it and comply with it at all times.

8.2 ROUTE

1. Development of the RUR by the DMSP in collaboration with the Head of Department and the Head of Service;

2. CEO approval of RUR.

8.3 MECHANISM

This RUR must be reviewed at the end of the first year following its initial approval by the CEO, and every 4 years.

8.4 APPROVAL, ADOPTION AND ENTRY INTO

The present RUR comes into force after being approved by the CEO.

The present RUR remains in force until a new version is adopted by the DMSP.

APPENDIX 1: SPECIAL COVERAGE

IMAGING

Access to plain X-rays and CT scans is available 7 days a week, 24 hours a day, in all MUHC facilities.

Access to other modalities (ultrasound, MRI) is also available 7 days a week, 24 hours a day, by contacting the radiologist or resident outside regular hours.

Ultrasound examinations are carried out according to the opening hours of each facility, depending on local availability. Outside these hours, the radiologist or resident on call must be notified.

Urgent **MRI** examinations must be discussed with the radiologist at all times. The addition of one urgent examination means the cancellation of another. They will be performed according to clinical priority.

Nuclear medicine examinations are only available during the day, from Monday to Friday.

LABORATORY

The majority of laboratory tests ordered in Emergency Departments are prioritized and performed 7 days a week, 24 hours a day. There are some more specialized tests. These can only be carried out during normal weekday hours, and will be ordered according to the patient's presentation.

The microbiology laboratory will also take samples 7 days a week, 24 hours a day.

APPENDIX 2: EXAMPLES OF DISCIPLINARY APPROACHES

1. Extended shifts -> request to report 30 minutes in advance of shifts
2. Restriction of certain shifts
3. Restriction on having trainees on shifts
4. Official complaint filed with the DMSP

APPENDIX 3: MODIFICATIONS TO THESE RULES FOR THE LACHINE HOSPITAL EMERGENCY DEPARTMENT

1. **Radiology** - Lachine's radiology technician is on call, at home, from 11:30 p.m. to 8 a.m., as needed.

2. **Intensive care consultations** - Lachine now has an intermediate care unit for sicker patients. For patients who require a more specialized ICU, the Lachine physician will speak to the ICU physician at the receiving hospital

3. **Code blues** - The emergency physician is responsible for "code blues" on the floor, and the hospitalist may consult the emergency physician for patients who have become too unstable to remain on the floor. The emergency physician can come to the floor to help, but must not be kept there for more than 30 minutes, after which he or she must be relieved by the hospitalist. Transfer must be organized by the hospitalist if the patient is admitted.

APPENDIX 4: TRANSFERS ACCEPTED BY CONSULTANTS

Rationale: The MUHC offers leading-edge services in many fields. In this context, consultants are often contacted directly to accept requests for transfer/assumption of responsibility. This memo has been written to support consultants when they are contacted directly.

Exception: This memo does NOT apply to trauma, pediatrics, STEMI or stroke patients, any other specific MUHC regional mandate or other service agreement.

Transfer requests fall into two categories:

1) Appartenance rules:

These calls come from other Emergency Departments wishing to transfer a patient to us as “known". Generally, these are managed directly by the emergency team, which determines eligibility according to the following criteria agreed upon by all Montreal DPSs:

a) Recent admission: Admitted within the last 45 days for the same reason.
b) Recent surgery: undergone surgery within the last 30 days (procedure-related request).
c) Regular follow-up: Regular follow-up in an MUHC clinic for the condition justifying the transfer request (excludes private clinics). (Follow-up within the last 4 months with scheduled appointment).
d) Cancer patients: on treatment for active cancer. (Excludes patients referred from another center only for radiotherapy and patients in remission).
e) All dialysis and transplant patients followed at the MUHC.

In addition to meeting one of these criteria, the patient must require or be likely to require admission (criteria 1, 2 and 3). For others, rapid ambulatory follow-up should be preferred to avoid a visit to the Emergency Department. (Patients followed up in private clinics are not included and will be refused by the ED. These should be managed by the attending physician in coordination with the ED).

2) Request for transfer to specialized care:

Before accepting, please consider:

a) Responsibility of our RUISS: Prioritize patients from our RUISS when accepting transfers. The care required should not be available in the local CISS/CIUSS.
b) Resource availability: Consider the current MUHC resources available for your specialty.
c) Critical care/interventional radiology needs: Be aware of these needs and make arrangements in advance, if necessary.

SUBJECT	RULES FOR THE USE OF EMERGENCY ROOM RESOURCES AT THE MCGILL UNIVERSITY HEALTH CENTRE (MUHC)

Procedure:

a) Inpatient transfer: Patients admitted elsewhere must be transferred directly to an inpatient bed, not via the Emergency Department (exceptions can be made with approval of ED physician) (Contact bed management or on-call nurse manager).
b) Transfers from other Emergency Departments: in these cases, coordinate with the Emergency Department (Glen x 32723, MGH x 43012) and be prepared to see the patient on arrival. The decision to admit or discharge the patient must be made quickly (within 4 hours). The specialist department is responsible for contacting the referring center in the event of the patient's return. If admission is required, this department assumes responsibility by default (unless intensive care or surgery is required).
c) Time-limited procedures: For primarily surgical procedures, establish a clear timetable for the patient's return to the referral facility, usually within 48 hours, in accordance with MSSS guidelines. Make sure the patient is aware of this.
d) All requests from James Bay and Nunavut are automatically accepted; please note that there are accommodation resources available for these patients. If the emergency can be bypassed, please make appropriate arrangements to see the patient in the clinic.

Our RUISS covers:

- **CIUSS West Island**: Lakeshore, Lasalle, St Mary's (Verdun: RIUSS U de M).
- **CIUSS Centre-Ouest**: Jewish General Hospital.
- **Montérégie Ouest**: Suroit, Anna-Laberge, Barrie-Memorial (Charles-Lemoyne and Pierre Boucher: RUISS U de M). Note that this region is part of the Montérégie shared by the McGill and U de M networks; referral center: Charles-Lemoyne.
- **CISS Outaouais**: Hull, Gatineau Papineau, Pontiac etc.
- **James Bay and Nunavik ISSC**: Includes James Bay Cree.
- **CISS Abitibi-Témiscamingue**: Includes Rouyn-Noranda, etc.

*Critical cases must be accepted if no alternative is available or reasonable regardless of the above.