	POLICY Number: 7311-60-002 Title: MOST RESPONSIBLE PHYSICIAN
Authorization [ ] President and CEO [X] Vice President, Finance and Corporate Services	Source: Director, Practitioner Staff Affairs Cross Index: Date Approved: November 14, 1994 Date Revised: May 22, 2015 Date Effective: May 29, 2015 Date Reaffirmed: Scope: SHR and Affiliates

DEFINITIONS

Consultant means the physician who is asked by the MRP to assess/examine the patient and provide opinions, recommendations and specialized procedures.

Family Physician means the physician who ordinarily assumes responsibility for the care of the patient in the community.

Most Responsible Physician (MRP) means the physician who initiates the admission of the patient to hospital, and who coordinates the care of the patient while in hospital. A physician can specify under whose care the patient is to be admitted, provided the physician initiating the admission contacts the other physician by personal contact. Subsequent transfers of responsibility should be made with the mutual agreement of both physicians involved.

Most Responsible Health Practitioner (MRHP) means the Health Practitioner who has the responsibility and accountability for the specific treatment/procedure(s) provided to a patient and who is authorized by Saskatoon Health Region (SHR) to perform the duties required to fulfill the delivery of such a treatment/procedure(s) within the scope of their practice and has admitting and discharge responsibilities and accountability as part of their privileges or contract of employment.

1. PURPOSE

The purpose of this policy is to identify who the Most Responsible Physician (MRP) is and their responsibilities.

2. PRINCIPLES

2.1 Saskatoon Health Region (SHR) and its practitioner staff/physician staff believe that one practitioner/MRP must be clearly identified as the most responsible practitioner/physician from the time of patient admission to discharge.

2.2 Consultants and MRHPs support the MRP for specific treatment/procedure(s) and ongoing care.

2.3 The MRP designation facilitates communication between physicians and hospital staff directly involved in providing patient care.

3. POLICY

3.1 Each patient admitted to an in-patient unit or registered in an Emergency Department or an out-patient area within SHR, for the purpose of medical, psychiatric or surgical assessment, diagnosis and/or treatment, will have a designated MRP or MRHP.

3.1.1 The MRP will be listed on the patient's admission record as the attending physician/MRP for that patient until discharge or transfer to another consultant assuming the MRP role.

3.1.2 The referring physician remains the MRP unless and/or until the consultant accepts care of the patient as the MRP.

3.2 The Vice President, Practitioner Affairs (Senior Medical Officer) and Department Heads have the authority to designate a MRP.[1]

4. ROLES AND RESPONSIBILITIES

4.1 Most Responsible Physician

4.1.1 The MRP is responsible for directing the medical/surgical/psychiatric care and treatment of the patient for the duration of the admission, emergency visit or clinic visit or until there is a transfer to another Most Responsible Physician, in accordance with this policy.

4.1.2 The MRP or designated physician on-call for the service is expected to return urgent calls from hospital staff concerning their patients, within fifteen (15) minutes by phone and to attend within thirty (30) minutes at the hospital. The individual initiating the call will determine the urgency. If the MRP is unable to return urgent calls from hospital staff concerning his/her patient within 15 minutes[2], the call may be forwarded to the physician on-call for that service.

4.2 Consultants

4.2.1 Patient/client review, examination and recommendation which may or may not include MRP status.

4.2.2 Respond to MRP requests to provide consultation and expertise for the treatment/diagnosis and care plan for the patient.

5. POLICY MANAGEMENT

The management of this policy including policy education, implementation and amendment is the responsibility of Director, Practitioner Staff Affairs.

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[1] Saskatoon Regional Health Authority Practitioner Staff Bylaws, 2008 Sections 7 and 8

[2] Specialist Emergency Coverage Program, Program Policies and Administrative Guidelines, Saskatchewan Ministry of Health and the Saskatchewan Medical Association, April 2014. http://www.health.gov.sk.ca/secp-policies-and-guidelines

6. NON-COMPLIANCE/BREACH

Non-compliance with this policy will result in a review of the incident by the office of Practitioner Affairs and the Senior Medical Officer (SMO). Non-compliance may result in disciplinary action, up to and including termination of employment and/or privileges with SHR.

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1. PURPOSE

The purpose of this procedure is to establish the process for identifying the MRP in various situations. It also establishes the transfer of responsibility process from one MRP to another.

2. PROCEDURE

Specific Situations

2.1 Elective Surgery and Procedural Events

2.1.1 The surgeon/proceduralist arranging the surgery/procedure will be the MPR at the time of the surgery/procedure.

2.1.2 In the event that the patient requires the attendance of an anaesthesiologist, the responsibility for the patient will be shared between the MRP and the anaesthesiologist during the procedure.

2.1.3 Upon discharge from the recovery area/procedure area to an in-patient unit (or home), the MRP, if changing, will be clearly documented on the patient's chart by the MRP surgeon/proceduralist.

2.1.4 Notification to and agreement with the MRP (Family Physician or Specialist) must occur.

2.2 Urgent/Emergency Surgery

2.2.1 The surgeon performing the procedure automatically becomes the MRP.

2.2.2 In the event that the patient requires the attendance of an anaesthesiologist, the responsibility for the patient will be shared between the MRP and the anaesthesiologist.

2.2.3 Upon discharge from the recovery area to an in-patient unit (or home), the MRP, if changing, will be clearly documented on the patient's chart by the MRP surgeon.

2.2.4 Proper notification to and agreement with the new MRP (Family Physician or Specialist) must occur.

2.3 Family Physician

2.3.1 The Family Physician remains the MRP when they personally admit the patient, or accept an admission through Emergency, unless they arrange otherwise with another physician.

2.4 Consults

2.4.1 When asking for a consultation, the MRP must indicate whether the request is for an opinion only, or a total transfer of MRP responsibility.

2.4.2 Referral to a specialist to do a consultation does not automatically imply transfer of MRP responsibility.

2.4.3 The MRP remains responsible until they transfer the patient using a process of proper notification to and agreement with a new MRP (Family Physician or Specialist).

2.5 From Emergency

2.5.1 The identified Emergency Department (ED) Physician is the MRP until the patient is discharged from the ED or another consultant physician (Family Physician/Specialist) has accepted responsibility for the patient.

2.5.1.1 ED Physicians will call the Consultant promptly when a decision to refer has been made (they will not batch consults prior to calling consultants). If the Consultant wants their resident to attend, the Consultant contacts their resident.

- With each consultation request, the ED Physician will clearly communicate the reason and level of urgency, being requested of the consulting service.
- The two services will agree to the level of urgency based on clinical judgment of the ED Physician in order to see the patient in an appropriate time.
- The ED Physician will use clinical judgment to determine if waiting for the results of pending tests will change the direction and character of the consultation. If pending results will not change the decision to consult, or what service to consult, the ED Physician will promptly notify the Consultant.

2.5.1.2 Consultants shall make every effort to respond promptly to requests by ED Physicians.

- In an emergency situation, the Consultant shall respond to the ED Physician by telephone within 15 minutes and be able to be onsite within 30 minutes. If the timeline for consultation cannot be met by the Consultant and the patient's condition warrants immediate attention, the ED Physician will contact the Consultant or intervene to stabilize the patient.
- In a specialty care situation, the Consultant shall respond to the ED Physician by telephone within 15 minutes and be on site within 30 minutes. If unable to respond, the Consultant contacts the on-call service to respond and forwards on to the department head if required.
- The standard time for the Consultant to make a decision regarding admission is two hours or less after the initial call to the consultation service is placed by the ED Physician (unless tests are delaying the decision e.g. CT/Ultrasound).

2.5.1.3 Medical Students: Upon agreement between the ED Physician and the Consultant Resident, Medical Students may perform the initial assessment for the consulting service. Notwithstanding this, the aforementioned targeted times for assessment and disposition will remain in effect.

2.5.1.4 Role of Residents and Medical Students: At no time during the consultation, assessment and disposition process will Residents or

Medical Students be expected to resolve the differences of opinion amongst Emergency staff and Consulting staff. These will always be the subject of direct professional communication between physicians, conducted always with a view to the best interests of patients.

2.5.1.5 All Consultants will document the date and time patient was seen, the time of decision to admit the patient, and plan of care for the patient.

- In the case of patients held in the ED awaiting inpatient admission, the Consultant will make rounds and communicate the plan of care for the patient to the ED staff. Documentation will include written orders and progress notes.

2.5.1.6 Orders in the ED

- Only the MRP indicated on the ED sheet (or the designated resident working with that MRP) is authorized to write orders on the ED sheet in the order section.

2.5.2 Other involved services are to write orders on a separate order sheet that needs to be dated and stamped with the patient's information and all orders to be signed by the order writer. No patient may be transferred from the ED to a unit until a new MRP has been identified and accepted responsibility.

2.5.2.1 Every consultation from an ED Physician, whether resulting in admission, discharge or transfer to another consulting service, shall result in communication between the ED Physician and Consultant as to the disposition and further care of the patient.

2.5.3 Transfer of care will be deemed to have occurred once notification and agreement with the Family Physician or Specialist has occurred.

2.5.3.1 The name of the MRP for the patient admitted through Emergency is documented on the patient's chart.

- All physicians will document the time the patient is seen, and time a decision is made to admit patients to an inpatient bed.
- ED Physician writes "consult *to Dr. " <insert name>*
- Consultant admits patient and documents "documented by ED Physician/admitting physician" on the patient's chart).
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2.5.4 Registration Services is notified by the Emergency nursing clerk (or charge nurse after hours) of the name of the MRP.

2.5.5 The Family Physician (if not listed as the MRP) will receive a notification that their patient was admitted to the ED and/or an in-patient unit. This notification will come from Registration Services.

2.5.6 In the event the patient and/or family member is unable to provide the name of a Family Physician, the patient will be admitted under the care of a specialist.

2.5.6.1 In rural facilities, if there is no Family Physician, the physician on call becomes the MRP.

2.5.7 A physician from any service may attend a patient in the ED as the MRP. This physician will remain the MRP until transfer of care is formally carried out or until the patient is discharged.

Emergency Department Overcapacity

2.5.8 ED Physicians and nursing staff are authorized to determine the number of inpatients that the ED can safely manage.

2.5.8.1 This number is dependent on ED workload, staffing, capacity and the acuity of patients in Emergency.

2.5.8.2 Once the threshold is reached, the Over Capacity Protocol and Clinical On-Call Protocol will be called by the ED Physician or Charge Nurse.

2.5.9 In an ED over-capacity situation and to expedite admission processing, ED Physicians, in agreement with the Consultant, may request beds for patients that have a high likelihood of requiring admission.

2.5.10 During over capacity, ED Physicians may admit patients with covering orders under the Consultant after a discussion has taken place and the ED Physician and the Consultant are in agreement.

Other Emergency Department Situations

2.5.11 If a patient is sent to the ED for direct evaluation by a MRP/Consultant, a decision to admit or discharge the patient will be made within two hours.

- If a patient is waiting to be seen by the Consultant who has been delayed, the ED Physician may see the patient and initiate any investigations/treatments to facilitate flow.
- If an emergency/urgent clinical situation arises with that patient, the ED Physician will intervene/stabilize and contact Consultant regarding change in status/situation.

2.5.12 If a patient remains in the ED awaiting admission for 12 hours and there are appropriate inpatient beds at another site, the patient should be transferred to that site.

- If this does not occur, the reason for this decision will be documented by Acute Care Access Line (ACAL) and reported to the appropriate Department Head.
- Consideration will be given to single site specialties and care requirements of the patient.
- The MRP/Consultant will follow the care of the patient to the site, or may transfer care to an alternate physician.
- All arrangements for transfer of care to another facility are the responsibility of the current MRP to arrange the transfer of care to a new MRP at the receiving facility (unless MRP status is being retained).

Rural EDs

2.5.13 In Rural EDs, where the ED Physician is also the on-call physician and covering for the MRP, he or she may admit as the MRP and provide care until transfer of care has occurred.

2.6 Intensive Care Units

2.6.1 The MRP for all ICU patients will be the physician who has overall responsibility for the ICU at the time.

2.6.2 The MRP for ICU will transfer as new physicians enter the scheduled rotation.

2.6.3 Upon discharge from the ICU to an in-patient unit (or home), the MRP will be clearly documented on the patient's chart by the MRP ICU Physician. The usual process of proper notification and agreement with the new MRP (Family Physician or Specialist) must be followed.

2.7 Services with on-call Rotations

2.7.1 Services with formal on-call rotations may transfer MRP responsibilities to the on-call physicians. This arrangement must be pre-arranged and documented.

2.8 Transfer of Responsibility

2.8.1 Change in MRP responsibility must be written on the Physician's Orders and documented on the patient's chart by the transferring physician, having first made contact with and receiving agreement from the accepting physician.

2.8.2 The receiving physician must sign his/her acceptance of MRP responsibility on the Physician's Order Sheet. This acceptance should be documented as soon as possible and will not exceed 24 hours.

2.8.3 MRP responsibility becomes effective only after the physician has accepted the care of the patient. Until such time, the transferring physician will continue to be the MRP.

2.8.4 If no agreement can be reached, the transferring physician will continue to be the MRP.

- Contact Department Head to designate MRP where required.

2.8.5 The physician assuming MRP responsibility of the patient must possess valid admitting privileges to the hospital.

2.8.6 Transfer of MRP responsibility for periods of absence beyond evening and weekend call situations (i.e. physicians on vacation, or absent for illness or other reasons) must be arranged in the manner outlined above. In such cases, transfer of responsibility will not be made to the on-call group situation. One physician must be named as MRP.

2.9 Documentation

2.9.1 Transfer of MRP acceptance and responsibility must be made on the Physician's Orders by the transferring physician (except on call evening coverage, see 2.7.1).

2.9.2 Nursing staff will record the name of the MRP on the Individual Care Plan at the top of the first page, above the addressograph stamp.

2.9.3 The admission history and physical is the responsibility of the MRP at the time of admission. In exceptional cases, a full consultation report is acceptable as a history.

2.9.4 The discharge summary is the responsibility of the MRP, at the time of discharge. Health Records will be able to determine the MRP at the time of discharge by tracking the MRP from the Hospital Admission-Separation Record through the Physician's Orders.

3. PROCEDURE MANAGEMENT

The management of this procedure including procedures education, monitoring, implementation and amendment is the responsibility of the Senior Medical Officer and Director, Practitioner Staff Affairs.

4. NON-COMPLIANCE/BREACH

Non-compliance with this procedure will result in a review of the incident by the Director, Practitioner Staff Affairs and the Senior Medical Health Officer (SMO). Non-compliance may result in disciplinary action, up to and including termination of employment and/or privileges with SHR.