The Scarborough Hospital
Policy & Procedure Manual
Administration - Role and Expectations of the Most Responsible Physician (MRP)

Purpose
To clarify and standardize the role of the Most Responsible Physician (MRP) at The Scarborough Hospital in order to ensure safe quality patient care and to optimize effective team functioning.

Policy
It is the hospital’s policy that all parties (physicians, health care teams and administration) are clear as to the identification of the Most Responsible Physician (MRP) for the care of each in-patient and registered outpatient, in order to facilitate:

- Accountability for patient care
- Patient safety and medical quality
- Effective team functioning and communication
- Appropriate bed allocation, patient flow and discharge planning

Most Responsible Physician (MRP) Responsibilities
As MRP, a physician will:
- Admit the patient to the hospital (acute or post-acute care)
- Indicate the admitting diagnosis of the patient upon admission and ensure discharge planning is initiated from the time of admission and communicated to the patient/family and health care team
- Take the lead in coordinating care of the patient by attending to the patient daily, including appropriate assessment, diagnosis, ordering of necessary tests and procedures, in a timely fashion; reviewing test results and acting upon results and documenting plan of care, outcomes and treatment and discharge plans
- Monitor the patient’s condition through rounding, communication with the key professional(s) involved in their care and documenting decisions and treatment plans
• Be responsible for communication with the healthcare team in a timely fashion
• Document need to transfer care; document acceptance of transfer of care (as required) and take accountability for the patient’s need while MRP (even if not related to original reason for admission)
• Communicate effectively and collaborate with the patient and/or significant others in a timely fashion
• Take the lead in managing ethical issues related to the care of the patient
• Discharge patient from hospital to another facility (including Complex Continuing Care or Rehabilitation) or home/LTC, with appropriate referrals for community support and care
• Designate patient as Alternate Level of Care (ALC) in accordance with provincial policy
• Respond, in a timely fashion, to telephone calls/pages, requesting input on patient care
• Completing requests for consultations with clear rationale, baseline information and the reason for the consultation.
• Personally speak with the requested consultant for urgent consultations
• Complete the necessary documentation, including prescriptions, for patient discharges

Note: In some circumstances, the MRP works in collaboration with a Nurse Practitioner who shares the MRP responsibilities listed above and/or an identified delegate

Procedure

1. The physician admitting the patient (writing the orders or calling the Admitting Department) will be the MRP until the transfer of care is completed as in step 4 OR
2. Until the completion of a work shift and the transfer of care can be directed to the admitting physician
3. Transfer of care for vacation, evening and weekend on call coverage, or during other absences, such as illness, shall be clearly communicated and documented
4. The transfer of care will occur only when the transferring physician receives verbal and/or written acceptance of the transfer from the receiving physician, at which time the order sheet will clearly outline the transfer of care plan
5. Other physicians attending the patient will be considered to be consulting at the request of the MRP unless care is transferred by physician order and accepted
6. MRP will follow the standards for consultation. The consultation request indicates:
   a. Reason for consultation
   b. Whether the MRP wishes i) recommendations only, ii) recommendations and orders, or, iii) assessment and transfer of MRP to the consultant
7. Patients who have had operative procedures will have the operating physician as MRP unless and until care is transferred by physician order and accepted
8. In urgent or emergent situations, the responding physician will assume immediate care (temporarily) until the MRP or delegate of record is reached

9. The MRP shall be responsible for documentation of:

   a. Admission Note that sets out clearly the reason for admission, within 24 hours of patient admission (unless History and Physical Exam and provisional diagnosis is recorded within this timeframe)
   b. History and Physical Exam within a maximum of 72 hours but prior to an anaesthetic being administered or an operation performed, other than where the delays caused by doing so would endanger the life, limb or vital organs of the patient. If the Admission Note includes a history, physical exam and provisional diagnosis, it would satisfy this requirement. This does not alter the responsibilities of the anaesthetist or surgeon
   c. Daily progress notes during the acute stages of a patient’s admission
   d. Regular updating of diagnosis, complications and anticipated date of discharge
   e. Operative note (if surgical case)
   f. Doctors Orders
   g. Transfer of care and coverage for weekends, vacations and other absences
   h. Discharge Summary/Final Note
   i. Summary Sheet and Final Diagnosis
   j. Authentication and completion of patient’s health record within 14 days of discharge of the patient

When care is transferred over the weekend, the plan of care, including discharge plan, is clearly communicated to the receiving physician, verbally or in writing and becomes the responsibility of the receiving physician.

Transfer of MRP Responsibilities in the Emergency Department

The emergency department (ED) physician shall coordinate the care of all patients in the ED until care is transferred to an accepting physician
Each successive emergency physician remains MRP until such responsibility has been transferred to an accepting MRP

The emergency physician has the responsibility to communicate directly to the physician to whom he/she wishes to transfer care

If the physician to whom the ED physician wishes to transfer care has not returned the ED physician’s page at the end of that ED physician’s shift, he/she will inform the ED physician on the next shift of any outstanding calls

It will be the responsibility of the ED physician on duty at the time to communicate with the potential MRP when he/she returns the call
Transfer of Patients out of the Intensive Care Unit, Cardiac Care Unit

1. Note that the CCRT RN will follow patients for 48 hours after an ICU patient transfer from the ICU/CCU to support their care. Patients will remain under the Intensivist while in the ICU/CCU even if waiting for a ward bed.

2. If a patient is transferred to a hospitalist ward, then a hospitalist will take over the patient's care from Monday to Friday. On Saturday and Sundays, the MRC group (General Campus) or Medicine Pickup GIM A (Birchmount Campus) will take over as MRP at 8am the next day.

3. If a patient is transferred to a non-hospitalist ward then the new MRP will be designated as follows:
   a. If the patient originated from a medical ward, the ward MD who was MRP prior to ICU admission would be designated as such.
   b. If the patient originated from a medical ward and at the discretion of the Intensivist (and in discussion with the health care team), an involved consultant may be designated MRP upon transfer to a non-hospitalist ward.
   c. If there is no such appropriate MD for MRP on the non-hospitalist wards as outlined above, then MRP responsibilities will be assigned to whoever is on call for the night call of the day of transfer (General Campus) or Pickup MRP (GIM A) at Birchmount Campus scheduled the following day.

4. The Intensivist remains MRP until handover at 0800 the subsequent day. The Intensivist will speak directly to the new MRP to provide proper handover.

5. MRP transfer would require the newly designated MRP to accept the patient after discussion with the Intensivist with clarification and documentation in the orders as to timing of transfer (same day or next day). The accepting ward MRP will endeavor to assume the MRP role the same day the transfer is requested if possible. The patient will be supported by the intensivist, CCRT and medicine on call until the patient is seen and taken over by the new MRP who should expect a phone call informing them of the transfer during the day shift preceding their night call shift.

6. If the Intensivist in conjunction with the health care team is unable to agree on which MD should be designated MRP upon Intensivist transfer from ICU/CCU, then the Chief of Medicine or delegate will be consulted and asked to facilitate.

7. The above transfer process applies to all ICU/CCU transfers 7 days a week.

Consultation Procedure (Excluding the Emergency Department)

1. MRP will follow the standards for consultation. They are:
   a. Consultation request indicates reason for consultation
   b. Priority of response Non-Urgent unless otherwise indicated
   c. Consultation request indicates whether the MRP wishes i) recommendations only, ii) recommendations and orders, or, iii) assessment and transfer of MRP to the consultant
2. **Non-Urgent Consultation**
   a. The MRP will order the consultation as per #1.
   b. The MRP will contact consultant directly and/or through discussion may delegate to the charge nurse
   c. The consultation to be entered to MEDITECH
   d. It is the responsibility of the MRP to follow up to ensure that there is a response to the request in a timely fashion (24 hours)
   e. Any escalation to the request for consultation is responsibility of the MRP
   f. Any escalation should be directed to the consultant initially notified

3. **STAT consultation**
   a. The MRP will speak to the appropriate consultant
   b. Priority extensions 8165 (General Campus) and 2506 (Birchmount Campus)
   c. The MRP to document in progress notes any expectations/accountabilities such as diagnostic tests to be ordered (and priority), medications and/or when consultant to assess patient
   d. If there is no response or inadequate response by the consultant to a STAT request, the request is to be escalated to the Site Chief and/or Division Head as applicable
   e. Further escalation to no response should be to the applicable Corporate Chief and lastly to Chief of Staff

**Consultation Procedure for the Emergency Department**

1. The ED physician shall contact consultant and/or through discussion may delegate to the charge nurse (following the standards for consultation as above)
2. The ED physician shall communicate directly to consultant regarding request and document time of notification.
3. Consultant shall see the patient as soon as possible following principles of triage and patient CTAS status
4. The assessment time is to be documented by printing a consult sheet with the appropriate patient information and time stamp
5. Escalation of no response inadequate response to a request for consultation to follow the process for STAT consultation as above.

**Paging and Escalation Procedure**

At **any time** during the paging and escalation process if the patient condition requires more immediate response, a page to the CCRT (Critical Care Response Team) should be done via Locating (STAT locating extension 3399)

Any member of the healthcare team can page CCRT by adhering to the CCRT criteria (as per policy 5.15.012 )
Criteria For Calling CCRT

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
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<tbody>
<tr>
<td>Airway</td>
<td>• Threatened&lt;br&gt;• Stridor&lt;br&gt;• Excessive secretions</td>
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<tr>
<td>Breathing</td>
<td>• Respiratory rate ≤ or ≥ 30&lt;br&gt;• Distressed breathing&lt;br&gt;• Saturations &lt;90% on ≥ 50% O2 or 6Litres/min</td>
</tr>
<tr>
<td>Circulation</td>
<td>• Systolic blood pressure ≤ 90mmHg or ≥ 200mmHg or decrease &gt;40mmHg&lt;br&gt;• Heart rate &lt;40 or &gt;130</td>
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<tr>
<td>Disability</td>
<td>• Decreased level of consciousness (GCS decrease &gt;2 points)</td>
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<tr>
<td>Other</td>
<td>• Urine output &lt;100mls over 4hrs(except dialysis patients)&lt;br&gt;• Serious concern about the patient</td>
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Non-Urgent Calls
1. Page the MRP via Locating (Locating will be able to direct call to MRP or delegate)
2. Use the SBAR tool (appendix B) to provide a clear and concise description of the assessment.
3. If there is no reply within a reasonable amount of time (10-15 minutes), page a second time.
4. If there is still no reply after a reasonable amount of time (10-15 minutes), page the Site Chief and/or Division Head as applicable.
5. If there no response (10-15 minutes) page the Corporate Chief
6. If there is no response within 15 minutes page the Corporate Chief of Staff
   **NOTE:** all calls to be placed through Locating
7. If the MRP is not on call: page the On Call Physician via Location. Follow steps 2-7)

Urgent Calls
1. Page the physician “STAT” who is on call for the service via locating.
2. Use the SBAR tool (appendix B) to provide a clear and concise description of the assessment.
3. If there is no reply within a reasonable amount of time (5-10 minutes), page a second time.
4. If there is still no reply after a reasonable amount of time (5-10 minutes), page the Site Chief and/or Division Head as applicable.
5. If there no response (5-10 minutes) page the Corporate Chief
6. If there is no response within 15 minutes page the Corporate Chief of Staff
7. If at any time during this process, the patient conditions requires more immediate response page CCRT or initiate Code Blue/Pink as appropriate

**NOTE:** all calls to be placed through Locating

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Appendix A- Paging and Escalation Process

Paging and Escalation Process

At any time during the paging and escalation process, if the patient condition requires more immediate response and the patient meets the CCRT calling criteria page the CCRT (Critical Care Response Team) via Locating

ALL calls to be placed via LOCATING

STAT Consultation

- MRP to speak directly with consulting physician

  - If there is no response to STAT request, escalate to the appropriate Site Chief and/or Division Head as applicable

    - No response
      - PAGE Corporate Chief

      - If there is no response from the Corporate Chief, escalate to the Chief of Staff

Non-Urgent Calls

- Page the MRP
  - Provide description of assessment using SBAR tool

    - No reply 10-15 minutes
      - Repeat page

    - No response to second page within 15 minutes
      - PAGE Site Chief and/or Division Head as applicable

    - No response 15 minutes
      - PAGE Corporate Chief

URGENT Calls

- Page the physician on call for the service STAT
  - Provide description of assessment using SBAR tool

    - If there is no reply within 5-10 minutes, repeat page

    - No response to second page within 10 minutes
      - PAGE Site Chief and/or Division Head as applicable

    - No response 15 minutes
      - PAGE Corporate Chief

    - If there is no response to request within 15 minutes
      - Escalate to the Chief of Staff

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Appendix B: SBAR Tool

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<thead>
<tr>
<th>S</th>
<th>Situation</th>
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<tbody>
<tr>
<td></td>
<td>A concise statement of the problem.</td>
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<tr>
<td></td>
<td><em>What is going on now?</em></td>
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<table>
<thead>
<tr>
<th>B</th>
<th>Background</th>
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<tbody>
<tr>
<td></td>
<td>Brief introduction related to the situation.</td>
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<tr>
<td></td>
<td><em>What has happened?</em></td>
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<table>
<thead>
<tr>
<th>A</th>
<th>Assessment</th>
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<tbody>
<tr>
<td></td>
<td>Analysis and considerations of options</td>
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<td></td>
<td><em>What you have found/think is going on?</em></td>
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<tr>
<th>R</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td></td>
<td>Request/recommend actions</td>
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<tr>
<td></td>
<td><em>What do you want done?</em></td>
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Reference TRI 2009