POLICY TITLE
MOST RESPONSIBLE PHYSICIAN (ACUTE CARE)

AUTHORIZATION
VICE PRESIDENT, QUALITY & PATIENT SAFETY

DATE APPROVED
SEPTEMBER 2010

DATE REVISED
3 AUGUST 2010

REASON FOR POLICY
To delineate the Most Responsible Physician (MRP) key accountabilities and responsibilities for the admission, ongoing care, transfer of care, consultation and discharge processes for in-patients to and from a Fraser Health acute care facility.

POLICY STATEMENT
The MRP is integral to the provision of quality health care, to the promotion of continuity of care and to the delivery of appropriate medical services. Every patient admitted for care and treatment in a Fraser Health Authority acute care facility must have a Most Responsible Physician who holds appropriate Fraser Health credentials and privileges and whose name shall be clearly identified in the patient’s health care record at all times during the patient’s hospitalization period.

APPLICABILITY
This policy applies to all Fraser Health medical staff.

PROCESS

1.0 Key Accountabilities and Responsibilities
The MRP is accountable and shall assume responsibility for the overall care provided to patients under their care regardless of the patient’s location and shall:

1.1 Be aware of each patient for whom they are responsible.
   When accepting care from the transferring physician, if necessary, review with the transferring physician and/or nursing staff the current medical orders for care of the patient.

1.2 Assess and examine the patient, document his/her findings on the chart and issue the applicable order(s) for the patient:
   • As warranted by the patient’s initial condition;
   • Within 24 hours of admission or acceptance of transfer of care or sooner depending on the patient’s condition.
1.0 Key Accountabilities and Responsibilities - continued

1.3 Communicate the patient's clinical status to the patient, the family/legal Guardian and the other members of the health care team as appropriate.

1.4 Ensure that each patient is seen by a physician or his/her designate as often as the patient’s condition warrants but not less than once each day while the patient remains under his/her care until such time as the patient is no longer designated an acute care patient. With the approval of the Health Authority Medical Advisory Committee (HAMAC) and the Executive Medical Director a Regional Department policy may allow for less frequent visitation to improve quality of care and patient safety.

1.5 Complete daily progress notes in accordance with the Health Authority's documentation standards.

1.6 Undertake transfer of care arrangements and initiate consultations as required and to communicate such arrangements to the patient, the family/legal guardian and the other members of the health care team.

1.7 Be available, in person or by appropriate communication channels, 24 hours a day, seven (7) days a week or clearly articulate the delegation to a designate with current Fraser Health site privileges.

2.0 Delegation of Responsibility
The MRP may delegate responsibility for the care of a patient to another appropriately credentialed member of the Fraser Health Authority’s Medical Staff or a Fraser Health Authority Nurse Practitioner. The MRP shall advise the members of the health care team of the delegation and document the delegate’s name and position on the patient’s health record unless the MRP is designated as a service. The MRP continues to have overarching responsibilities for the care of the patient.
2.1 The MRP can be designated as a service rather than an individual if it fulfills the criteria listed in terms of coverage and notification and is appropriate for the hospital and patient care. For services where MRP responsibility is shared by a group and/or teaching practice, the Regional Department Head or his/her identified delegate for the service will be responsible for ensuring that a schedule of physician coverage is made readily available to the health care team. The schedule of coverage will be posted in advance and any changes updated immediately. It is the responsibility of the individual physician to find a replacement if they will not be available to cover their shift. The schedule of coverage will include the name of the physician who is covering during a specified period of time and his/her contact numbers. The schedule will be kept on file in FHA for the same period of time as medical records. In the event that a physician on the schedule is not available for any reason, the Regional Department Head or his/her identified delegate will be contacted and will be responsible for providing coverage for the service.

2.2 Routine coverage by the on-call group for the MRP will be documented and this information will be made readily available on the wards and to all medical and nursing staff within FHA.

3.0 Transfer of Care
The transfer of a patient’s care may be necessary to ensure continuity of care and access to appropriate medical services. This should occur only if necessary during the acute care stay.

Where an in-patient transfer of care is deemed appropriate by the MRP:

3.1 The MRP shall personally contact the intended accepting physician to obtain an agreement to accept transfer of care. Personal notification is expected in all circumstances.

3.2 The transfer of care takes place upon the acknowledgement of the accepting physician during a physician to physician verbal discussion between the transferring physician and the accepting physician. The transferring physician is responsible to document in the chart the name of the physician who has accepted the transfer of care either for him/herself or on behalf of the physician.
group, along with the date and time of the verbal discussion that has occurred between the two physicians. An order must be written in the patient’s health care record by the transferring physician instructing registration staff to change the name of the MRP to the accepting physician’s name or to the accepting service. The name of the physician who accepts the care of the patient for a service will be written on the order sheet to document the transfer of MRP care to the service and the registration will show the service name as MRP.

3.3 The accepting physician or designate shall assess and examine the patient, document the findings and issue applicable order(s) as soon as warranted by the patient’s condition but not longer than 24 hours after accepting the transfer and not less than once a day thereafter for as long as the patient remains under his/her care while the patient is deemed an acute care patient.

3.4 The physician or designate accepting the transfer of care of a patient awaiting long term care placement shall assess and examine the patient as soon as warranted by the patient’s condition but not longer than 24 hours after accepting the transfer and thereafter at least once during a seven (7) day period while the patient remains admitted to an acute care facility.

4.0 Consultations
Physicians are encouraged to obtain appropriate consultations that facilitate and enhance patient care. In the event a consultation is requested, the MRP shall:

4.1 Where possible, notify the patient and/or the patient’s family/legal guardian of the purpose of the consultation and the name of the consultant.

4.2 Communicate directly with the consultant physician, or their designate, for any patients requiring an in-hospital consultation as per the B.C. College of Physicians and Surgeons guidelines unless Regional Department approved policy describes automatic consultation for a specified service.

4.3 Ensure that the reason(s) and purpose for the consultation request is appropriately documented on the patient’s health record.
4.4 The consultant or designate shall assess, examine the patient and document the findings, opinions and recommendations on the patient’s health care record as soon as warranted by the patient’s condition but not longer than 24 hours from receipt of notification unless otherwise arranged.

Parameters for the role of the consultant are outlined below:

a) **Consultation Only** - Consultant asked to make an assessment and provide management suggestions. These suggestions will be written within the consult note and/or progress notes. The consultant is not expected to write ongoing orders or to provide follow-up. In this case the MRP remains the same, and the consultant does not write orders.

b) **Consultation with Directive Care** - The consultant assists with the ongoing care of the patient including writing appropriate orders and follow-up. The consultant is not the MRP. The referring physician remains as the MRP. Clarification of any orders will first be the responsibility of the physician writing the orders with the MRP responsible for final clarification if necessary.

c) **Consultation with Continuing Care (Transfer of Care)** - Consultant takes over the entire care of the patient and becomes the MRP. This initiates a transfer of care and the consultant accepts care of the patient as the MRP and includes all patients that have been taken to the operating room for major surgery.

In the absence of clear direction, direct communication by the consultant with the MRP should be undertaken for clarification. The default obligation of the consultant is an appropriate review, examination and recommendations only.

4.5 **Emergency Department Consultations and Shift Change Transfer of Care**

4.5.1 The members of the Department of Emergency Medicine remain responsible for the care of all patients in the Emergency Department until such time as:

- The patient is discharged from the Emergency Department; or
- Patient care is transferred to an accepting MRP.

For all patients in the Emergency Department that have not been discharged or transferred
to an accepting MRP at the time of shift change for the Emergency physician, a transfer of care will occur between the Emergency physician completing their shift and the Emergency physician starting their shift. This transfer of care will take place upon the acknowledgement of the accepting Emergency physician during an Emergency physician to Emergency physician verbal discussion between the transferring physician and the accepting physician. The transferring Emergency physician is responsible to document in the chart the name of the Emergency physician who has accepted the transfer of care of the patient in the Emergency Department, along with the date and time of the verbal discussion that has occurred between the two physicians.

4.5.2 Where a patient is admitted from the Emergency Department to an in-patient unit at the same site, the Emergency physician will be identified as the ADMITTING physician. The MRP will be identified as the ATTENDING physician. The ATTENDING physician assumes MRP responsibility for the patient as soon as the transfer of care has been arranged with the Emergency Physician.

4.5.2.1 Where a patient is admitted from another hospital or from the community directly to an inpatient bed (or into the ER if no inpatient bed is available) for elective surgery or continued inpatient care in an acute care facility, the physician who has arranged the elective surgery or inpatient care, will be identified as both the ADMITTING and ATTENDING physician. The physician who has accepted the transfer from another facility or directly from the community will be identified as both the ADMITTING and ATTENDING physician.

4.5.3 In the case where a physician is consulted for a patient in the Emergency Department and recommends admission of the patient, the consultant will be the MRP for the patient. If the admission cannot occur on that site, as MRP, the consultant should arrange the admission of the patient and transfer of care to a physician/colleague on an alternative site. If the consultant does not have admitting privileges and recommends admission, the consultant will discuss the recommended admission with the physician who is most appropriate to provide care for the patient and arrange for admission with the acceptance of that physician and the agreement of the referring Emergency Department physician. This
communication will take place even if the most appropriate physician to provide care for the patient until the transfer occurs is the referring Emergency Department physician. The consultant must provide suggestions for care and ongoing management of the patient to the accepting physician.

4.5.4 In the case where a physician is consulted for a patient in the Emergency Department and after assessing the patient the consultant has determined the patient’s admission is not appropriate for their specialty area, the consultant should discuss the case with the Emergency Department physician and in conjunction with the Emergency Department physician, a decision is made as to whom the most appropriate consultant would be and who initiates that consultation. If the Emergency Department physician who made the initial request for consultation has already completed their shift when the consultant has completed his/her assessment, the consultant will discuss the case with the on duty Emergency physician who has accepted ongoing care of the patient from the Emergency physician who has completed their shift.

5.0 Health Care Team Member Responsibilities

5.1 The patient’s nurse (or designate), Clinical Associate/Assistant or Resident shall immediately notify the MRP (or designate):
   • Of any significant change in the patient’s condition; and
   • document the above actions in the patient’s health record.