St.Mary's GENERAL HOSPITAL

GRAND RIVER HOSPITAL
Advancing Exceptional Care

# Consultant Coverage of the Emergency Department Policy & Procedure

## Purpose

The purpose of this policy is to ensure timely and safe consultative service to the patients requiring care in the Emergency Department. All permanent (Active, Associate and Locum Tenens*) Professional Staff of Grand River Hospital (GRH) and St. Mary's General Hospital (SMGH) shall participate in the on-call roster for their specialties as outlined in the Professional Staff Rules and Regulations. All Professional Staff shall have a common goal to ensure the highest quality of patient care, and to maintain professional conduct.

## On-Call Schedule

The Chief of Department of each department or Head of Service, or designate, shall ensure that their respective daily on-call coverage schedules are published/available on PetalMD before the first of each calendar month.

## Responsibility

### ED Physician

It is the responsibility of the Emergency Department physician to assess the patients presenting to the emergency department (ED), determine the likely diagnosis(es) and organize the reasonably appropriate tests to support the diagnosis.

If the ED physician determines that one or more consultant physician(s) need to become involved in the patient's care, to either offer an opinion or to manage the patient, then he or she should request the consultation.

Oftentimes, the ED patient needs to be admitted to hospital and he/she will be admitted under the care of the on-call consultant best equipped to deal with the most important diagnosis of that ED patient. The Emergency Physician has the responsibility to comply with the **Guidelines for Most Appropriate Service for Emergency Admissions** (revised by MAC in 2016).

The ED physician is not responsible for initiating admission orders but rather holding orders until the On-Call consultant can write the actual admission orders. The ED physician is expected to initiate the holding orders between the hours of 10:00 pm and 7:00 am only, if requested, but otherwise the On-Call consultant is responsible to write the admission orders at the time of admission.

### On-call Consultant

The on-call physician needs to complete an appropriate consultation once this is requested from the ED.

If there is a disagreement between the Emergency Physician and the initial Consulting physician as to which service is most appropriate, the Emergency Physician shall retain final decision.

In the event a consultant has assessed the patient referred by the ED physician but feels the patient requires consultation by another service, the initial consultant shall write a note of his/her clinical assessment on the patient chart and he or she should request the consultation.

If an on-call consultant requests a consultation from a different service, then rules outlined in this policy will still apply, i.e. the first on-call consultant will effectively become the ED physician.

## Communication

The referring ED Physician (or designate learner) shall speak personally with the On-Call consultant (or designate learner) for the specific service that is deemed the most appropriate (determined by the referring ED physician), to convey pertinent details of the patient's condition and urgency of the consultation.

## Consultant Response Times

### Telephone Response

**Telephone response time is to be within 15 minutes by the On-Call consultant or designate.**

If the On-Call consultant is busy performing a procedure, a designate must return his/her call to the ED or unit and talk to referring physician to assess the nature of the case. The referring physician or designate must still be available for communication with the On-Call physician at a later time, if necessary.

To facilitate prompt telephone response times, hospital staff (as delegated by the On-Call consultant) will respond to pages in case the On-Call consultant is busy performing a procedure to record/convey the appropriate information.

### Physical Presence

On-Call consultants are required to be able to physically reach the hospital within a specified period of time to respond to potential life or limb threatening emergencies**.** Due to the nature of their respective practice and area of expertise, consultants from some specialties are required to remain within 30 minutes of the hospital while others may be as much as 1 hour away, as listed in the table below.

| Physical presence within 30 minutes or less | Physical presence within 60 minutes or less |
|---|---|
| Anesthesia | Diagnostic Imaging |
| Cardiovascular Services | Geriatric Medicine |
| Critical Care Medicine | Hospitalist Medicine |
| Gastroenterology | Infectious Diseases |
| OB & GYN | Lab Medicine |
| Pediatrics | Nephrology |
| All Surgical Specialties | Nuclear Medicine |
| | Oncology |
| | Psychiatry |
| | Pulmonary Services |
| | Other Medicine Specialties (GIM, Endocrinology) |

In case of actual life or limb threatening emergency, on-call consultants are to attend the patient as soon as possible. If the patient requires immediate attention and the consultant is unavailable (i.e. doing a procedure), then this constitutes a crisis situation and all concerned need to be involved in resolving the crisis as well as possible.

Cardiologist on call for CCU at SMGH will be physically present within 30 minutes for SMGH ED. For GRH ED, activation of CODE STEMI will result in emergent transfer for STEMI patients to SMGH. For all other cardiac presentations to GRH ED, consultation to Internal Medicine or Critical Care at GRH, as appropriate, with admitting MRP to request inpatient Cardiologist consultation, as deemed necessary.

For any life threatening Airway Emergency, the on-call Anesthesiologist is required to attend to the patient as soon as possible, except in rare situations, when both the first and second on-call Anesthesiologists aren't immediately available (for example both are doing a case in the OR).

### Patient Disposition

Once the ED physician has completed their assessment of a patient, including reasonable tests and procedures, and once a consultation has been requested of an On-Call consultant, then the On-Call consultant is required to organize the patient disposition from the ED, consisting of either admitting the

patient to his/her care, discharging the patient from the ED or requesting a consultation of a different service. Further testing or procedures done in the ED will not be considered as patient disposition.

The time to patient disposition should be less than 1 hour and this is deemed a priority in the management of an ED patient. There may be some clinical situations in which the patient may require further investigations or procedures in the ED, which will result in longer patient disposition times, but for the overwhelming majority of patients the disposition time should be less than 1 hour.

Consultations from the ED will be called at the time the patient requires disposition, regardless of the time of day.

Admitting consultants shall be responsible for ensuring that admitting orders are correct. To facilitate the prompt disposition of ED patients, the ED physician will make every effort to assist the On-Call consultant in initiating the holding orders, if requested between 10pm and 7am.

## Monitoring and Feedback

### Telephone Response

If the referring physicians feel that the phone response times from an individual consultant or department are consistently longer than required, a monitoring process may be instituted. The affected consultant(s) need to be informed of the monitoring to be able to check the accuracy of that process. If it is indeed shown that the respective response times are inappropriately long, then corrective measures will be implemented by the affected consultant, Department Chief or Chief of Staff, as necessary.

### Disposition Time

The disposition time for every patient shall be recorded. The 90$^{th}$ percentile patient disposition time for every On-Call consultant shall be reported (this is the time up to which 90% of a consultant's patients have to wait for disposition). The goal is for the 90$^{th}$ percentile patient disposition time to be less than 1 hour.

The department chiefs/chief of staff shall review the disposition times of all On-Call physicians and shall supervise and institute changes in the practice and procedures of consultants/departments that have disposition times longer than required.

The 90$^{th}$ percentile patient disposition time shall form part of the performance evaluation of staff physicians.

## Disagreement & Code of Conduct

Disagreements amongst the referring physician and the On-Call consultant shall be handled with courtesy, respect and dignity for one another. Physicians must refrain from arguments with each other in work areas that may be overheard by patients, visitors, or employees or other non-involved individuals. Physicians must also refrain from conduct, which may reasonably be considered abusive or threatening, whether the threat is expressed or implied.

After the consultant has seen the patient, if he/she feels the consult was inappropriate, and if the involved parties cannot resolve the issue between themselves, then either physician can contact the respective Chiefs of their departments. If there is still no resolution, then the matter can be referred to the Chief of Staff.

## Consequences of Failure to Comply

Physicians, both referring and consulting, who do not act in accordance with this policy and standards of conduct, shall be subject to the complaint review process as outlined in the Professional Staff Code of Conduct and Complaint Management Policy.

MAC Approval: November 11, 2014

Revised: September 30, 2021