CAMBRIDGE MEMORIAL HOSPITAL

MEDICAL / PROFESSIONAL STAFF

RULES AND REGULATIONS

Approved by the Board of Directors

SEPTEMBER 29, 2021

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I. INTRODUCTION

The *Public Hospitals Act* requires the Medical Advisory Committee to make recommendations to the Board on the establishment of Clinical Rules and Regulations and General Rules and Regulations for the Medical/Professional Staff.

The By-law provides that the Board, after consulting with the members of the Medical/Professional Staff Association Executive and considering the recommendation of the Medical Advisory Committee, may make Rules and Regulations as it deems necessary, including rules and regulations for patient care and safety and the conduct of members of the Medical Staff, Dental Staff, Midwifery Staff, and Extended Class Nursing Staff.

These are the Rules and Regulations contemplated by the *Public Hospitals Act* and the By-law.

II. DEFINITIONS

For the purposes of these Rules and Regulations:

1. **"Active Staff", "Affiliate Staff", "Associate Staff", "Courtesy Staff", "Locum Tenens Staff",** and **"Senior Emeritus Staff"** each describes a category of the Medical/Professional Staff, as is more particularly described in the By-law.

2. **"Basic Practice Privileges"** has the meaning given to it in Section A2(b).

3. **"Board"** means the governing body and board of directors of the Cambridge Memorial Hospital.

4. **"By-law"** means the Medical/Professional Staff By-law of the Hospital, as amended from time to time.

5. **"Certificate of Professional Conduct"** means the form provided by the CPSO that verifies that a doctor is registered and their standing with the CPSO.

6. **"Chief Executive Officer"** means in addition to 'administrator' as defined in the *Public Hospitals Act*, the President and Chief Executive Officer of the Corporation.

7. **"Chief Nursing Executive"** means the senior nursing employee responsible to the Chief Executive Officer for the nursing services provided in the Hospital.

8. **"Chief of Department"** means the member of the Medical/Professional Staff appointed by the Board to be responsible for the professional standards of the Medical/Professional Staff, and the quality of care rendered by members of his/her Department at the Hospital.

9. **"Chief of Staff"** means the member of the Medical/Professional Staff appointed by the Board to be responsible for the professional standards of the Medical/Professional Staff, and the quality of professional care rendered at the Hospital in accordance with the Hospital Management Regulation.

10. **"Clinical Human Resources Plan"** means the plan developed by the Chief Executive Officer in consultation with the Chief of Staff and Chiefs of Department and others based on the mission, vision, values and strategic plan of the Corporation and the resources of the Hospital, which plan provides information and future projections of this information with respect to the management and appointment of persons who are or may become members of the Medical/Professional Staff.

11. **"Clinical Rules and Regulations"** means rules and regulations for clinical practice for all Departments, Divisions, or Programs.

12. **"College"** means, as the case may be, the CPSO, the Royal College of Dental Surgeons of Ontario, the College of Midwives of Ontario and/or the College of Nurses of Ontario.

13. **"Corporate Manual"** means a manual where the Corporation's policies are maintained.

14. **"Corporation"** means the Cambridge Memorial Hospital.

15. **"CPSO"** means the College of Physicians and Surgeons of Ontario.

16. **"Credentials Committee"** means the committee established by the Medical Advisory Committee to review applications for appointment and reappointment to the Medical/Professional Staff and to make recommendations to the Medical Advisory Committee and if no such committee is established it means the Medical Advisory Committee.

17. **"day"** means a calendar day.

18. **"Dental Staff"** means the Dentists and Oral and Maxillofacial Surgeons to whom the Board has granted Privileges to treat Patients in the Hospital.

19. **"Dentist"** means a member in good standing with the Royal College of Dental Surgeons of Ontario to whom Privileges have been granted.

20. **"Department"** or **"department"** means an organizational unit of the Medical/Professional Staff to which members with a similar scope of practice have been assigned.

21. **"Division"** or **"division"** means an organizational unit of a Department.

22. **"EPR"** means enhanced performance review.

23. **"Ex-Officio"** means membership by virtue of the office and includes all rights, responsibilities and power to vote, except where otherwise stated.

24. **"Extended Class Nursing Staff"** means those Registered Nurses in the Extended Class who are not employed by the Hospital and to whom the Board has granted Privileges to diagnose, prescribe for, or treat patients in the Hospital.

25. **"Extended Privileges"** has the meaning given to it in Section A2(c).

26. **"General Rules and Regulations"** means the administrative rules and regulations for all Medical/Professional Staff and for Departments, Divisions, or Programs.

27. **"Head of Division"** means a Physician on the Active Staff who is appointed to be accountable to the Chief of Department for the delivery of a particular service within that department.

28. **"Hospital"** means the health care facility owned and operated by the Cambridge Memorial Hospital.

29. **"Hospital Management Regulation"** means Regulation 965 "Hospital Management" passed pursuant to the *Public Hospitals Act.*

30. **"ICU"** means the Hospital's intensive care unit.

31. **"Impact Analysis"** means a study conducted by the Chief Executive Officer or designate, in consultation with the Chief of Staff, Chiefs of Department and others to determine the impact upon the resources of the Corporation of the proposed or continued appointment of any person to the Medical/Professional Staff.

32. **"Interdisciplinary Clinical Manual"** means a manual where the Corporation's policies for clinical practice are maintained.

33. **"Medical Advisory Committee"** means the Medical Advisory Committee appointed pursuant to the By-law.

34. **"Medical/Professional Staff"** means those Physicians, Dentists, Midwives, and non-employed Registered Nurses in the Extended Class who are appointed by the Board and who are granted specific Privileges to practice medicine, dentistry, midwifery, or extended class nursing, respectively, in the Hospital.

35. **"Medical/Professional Staff Association Executive"** means the President, Vice-President, Secretary and Treasurer (if appointed) of the Medical/Professional Staff Association.

36. **"Medical Staff"** means those Physicians to whom the Board has granted Privileges to treat Patients and practice medicine in the Hospital.

37. **"Midwife"** means a member in good standing of the College of Midwives of Ontario to whom Privileges have been granted.

38. **"Midwifery Staff"** means those Midwives who are appointed by the Board and granted Privileges to practice midwifery in the Hospital.

39. **"M/PSA"** means the Medical/Professional Staff Association.

40. **"MRP/D/M"** means the admitting Physician, Dentist, or Midwife or such professional to whom the Patient has been transferred, from time-to-time, in accordance with these Rules and Regulations.

41. **"Oral and Maxillofacial Surgeon"** means a Dentist in good standing who holds a specialty certificate from the Royal College of Dental Surgeons of Ontario authorizing practice in oral and maxillofacial surgery.

42. **"Patient"** means, unless otherwise specified or the context requires, any in-patient or out-patient of the Hospital.

43. **"Physician"** means a member in good standing of the College of Physicians and Surgeons of Ontario to whom Privileges have been granted.

44. **"President of Medical/Professional Staff"** means the member of the Medical/ Professional Staff elected, from time to time, to the position of President by the Medical/Professional Staff;

45. **"Privileges"** means those rights or entitlements conferred upon a Medical/Professional Staff member at the time of appointment or reappointment.

46. **"Program"** means a collection of clinical services and health care practitioners to provide care and services to a group of Patients as defined by the Hospital.

47. **"*Public Hospitals Act*"** means the *Public Hospitals Act* (Ontario) and, where the context requires, includes the regulations made under it.

48. **"Registered Nurse in the Extended Class"** means a member of the College of Nurses of Ontario who is a registered nurse and who holds an extended certificate of registration under the *Nursing Act, 1991*.

49. **"Residents"** are medical learners who are physicians who have an educational certificate from the CPSO and are registered in a post-graduate program of an Ontario university.

50. **"Rules and Regulations"** means the provisions approved by the Board concerning the practice and professional conduct of the members of the Medical Staff, Dental Staff, Midwifery Staff, and Extended Class Nursing Staff in the Hospital both generally and within a particular Department.

51. **"Secretary of the Medical/Professional Staff Association"** means Secretary as defined pursuant to the By-law.

52. **"Treasurer of the Medical/Professional Staff Association"** means Treasurer as defined pursuant to the By-law.

53. **"Vice-President of Medical/Professional Staff"** means the member of the Medical/ Professional Staff elected, from time to time, to the position of Vice-President by the Medical/Professional Staff.

III. MEDICAL/PROFESSIONAL STAFF RULES AND REGULATIONS

1. These Rules and Regulations are written pursuant to the requirements of the *Public Hospital Act* and the By-law.

2. These Rules and Regulations are in addition to the requirements of the *Public Hospital Act* or the By-law.

3. These Rules and Regulations are subordinate to the By-law.

4. Medical/Professional Staff members must comply with these Rules and Regulations.

5. As related to Registered Nurses in the Extended Class, these Rules and Regulations apply to those who are not employed by the Hospital and to whom the Board has granted Privileges. These Rules and Regulations do not apply to Registered Nurses in the Extended Class who are employees of the Hospital.

6. From time to time, each Department shall develop Rules and Regulations, which, when approved, shall be considered a part of these Rules and Regulations, and with which members of the relevant Department, Division, or Program must comply.

7. Professional Staff members who are non-compliant with these Rules and Regulations may be subject to the progressive discipline process set out in these Rules and Regulations, General Rules #11 Progressive Discipline.

IV. ESTABLISHMENT AND AMENDMENT OF RULES AND REGULATIONS

1. The Medical Advisory Committee shall make recommendations to the Board on the establishment of Rules and Regulations after considering the recommendations of the members of the Medical/Professional Staff Association Executive.

2. The Medical Advisory Committee shall make recommendations to the Board on amendments to the Rules and Regulations as may be necessary.

3. The Medical Advisory Committee shall make recommendations to the Board on the establishment of Department, Division, or Program Rules and Regulations after giving consideration to the recommendations of the Departments, Divisions, or Programs affected.

4. The establishment and amendment of Rules and Regulations should be discussed at:

   (a) the appropriate Department/Division/Program meeting;

   (b) a Medical/Professional Staff meeting;

   (c) a Medical Advisory Committee meeting; and

   (d) a Board meeting.

5. Notice specifying the proposed amendment(s) to these Rules and Regulations shall be circulated in writing to the M/PSA members and the Medical Advisory Committee at least 30 days before the meeting at which the amendment(s) will be considered and may also be posted in a conspicuous place at the Hospital.

6. These Rules and Regulations will be reviewed at least every three years.

A GENERAL RULES

MEMBERSHIP

1. Appointment

Appointment will be undertaken as per the qualifications, criteria and procedures established in the By-law.

2. Privileges

(a) Medical/Professional Staff members of the Active, Associate, Courtesy, Affiliate, Locum Tenens, Senior Emeritus, and other categories of the Medical/ Professional Staff will apply for Privileges at the time of their application for appointment or reappointment.

(b) Basic Practice Privileges are Hospital practice Privileges of a Medical/Professional Staff member that fall within the current practice of the members of the Department, Division, Program, and/or subspecialty ("**Basic Practice Privileges**").

(i) Basic Practice Privileges for Affiliate Staff provide the ability to:

(A) visit their Patients in the Hospital and write progress notes;

(B) write orders for out-Patients only;

(C) see Patients on Hospital premises "in consultation" when asked by another Physician with Active, Associate or Courtesy Staff Privileges at the Hospital;

(D) assist in the operating room; and

(E) as otherwise specified in section 7.5 of the By-law.

(ii) Basic Practice Privileges for Active, Associate, and Courtesy Staff with admitting Privileges provide the ability to:

(A) in respect of a Physician, Dentist, or Midwife, admit Patients and be designated the MRP/D/M for Patients;

(B) in respect of a Physician, Dentist, or Midwife, perform surgical and other specialized medical practices and/or procedures, as will be

defined from time to time by the Board on the recommendation of the Medical Advisory Committee;

(C) visit their Patients in the Hospital and write progress notes;

(D) perform surgical assistance at the invitation of the attending surgeon, if it is within the Professional Staff member's scope of practice;

(E) perform consultations on Patients when requested;

(F) give orders for Patient care; and

(G) as otherwise specified in sections 7.2, 7.3, and 7.4 of the By-law, respectively.

(c) Extended Privileges are Hospital practice Privileges of a Medical/Professional Staff member that fall outside the current practice of the majority of the Department, Division, Program, or subspecialty, and as recommended by the Medical Advisory Committee ("**Extended Privileges**").

(d) Each Department, Division, Program, and sub-specialty may develop Extended Privileges specific to their Department, Division, Program, or sub-specialty. These Privileges will be outlined in the respective Department, Division, Program, or sub-specialty Rules and Regulations.

(e) Each Medical/Professional Staff member has a duty to participate in meetings, committees, or task groups, which from time to time may be requested.

(f) Requested Privileges for a Medical/Professional Staff member should be specifically outlined by the applicant at the time of application and subsequent annual reappointment.

3. Annual Re-application Process

Annually, the Chief of Staff shall review the following factors, as appropriate, in relation to each applicant:

(a) quality of care issues;

(b) ability to communicate effectively with Patients and staff;

(c) Patient/staff complaints;

(d) ability to supervise staff, Residents, and/or students;

(e) monitoring of Patients;

(f) on-call participation;

(g) staff and committee responsibilities;

(h) participation in continuing education programs;

(i) health record documentation;

(j) appropriate and efficient use of Hospital resources;

(k) effect of appointments to other hospitals on the Medical/Professional Staff member's duty/obligations and quality of care provided to Patients at the Hospital;

(l) disciplinary actions;

(m) Clinical Human Resource Plan and succession planning in accordance with Hospital policy;

(n) willingness to participate in the discharge of Medical/Professional Staff member obligations; and

(o) general compliance with the By-law and these Rules and Regulations, and confirmation that the applicant will continue to abide by the By-law and these Rules and Regulations.

4. Orientation for New Medical/Professional Staff

(a) All new Medical/Professional Staff members shall undergo an orientation, including both a general orientation to the Hospital and an orientation to the Department, Division, or Program concerned.

(b) The Chief of Staff shall be responsible for the new Medical/Professional Staff member's orientation to the Hospital.

(c) The Chief of Department shall be responsible for the new Medical/Professional Staff member's orientation to the functions, expectations, and Rules and Regulations of the respective Department, Division, or Program. The orientation should involve the appropriate Medical/Professional Staff members, the Hospital management and/or other staff resources and should include both clinical and facility orientation.

(d) Areas that should be covered by the orientation include:

(i) Hospital's mission, vision, and values,

(ii) Hospital's By-law and Rules and Regulations,

(iii) Department, Division, and Program policies,

(iv) On-call coverage requirements and procedures,

(v) Fire safety,

(vi) Disaster response plan,

(vii) Security and emergency numbers,

(viii) Professional staff facilities and room numbering systems,

(ix) Emergency code procedures,

(x) Press releases and media contact,

(xi) Health Records and relevant Health Information Management policies Corporate Manual Policy #12-34 Health Record Completion,

(xii) Conflict of interest,

(xiii) Confidentiality of Patient information,

(xiv) Workplace harassment and violence, and

(xv) any other relevant information.

5. Signature

Medical/Professional Staff who are joining the Hospital are required to produce a sample signature at the Office of the Medical/Professional Staff for the Pharmacy Department and Health Information Management Department.

6. Identification

All Medical/Professional Staff are required to wear a Hospital-issued identification badge while on site.

7. Confidentiality/Privacy

(a) Every Medical/Professional Staff member shall strictly observe the right of all Patients, families, employees, and other staff to privacy and confidentiality.

(b) Every Medical/Professional Staff member shall comply with the requirements of all relevant legislation and professional standards, including the *Personal Health Information Protection Act, 2004* (Ontario), the *Public Hospital Act*, their professional obligations of their College, these Rules and Regulations, and Hospital policies.

(c) Every Medical/Professional Staff member is expected to complete a "Confidentiality Agreement" form upon appointment.

(d) Every Medical/Professional Staff member shall respect the confidentiality of matters brought before Medical/Professional Staff committees and meetings, keeping in mind that unauthorized statements could adversely affect the interest of the Hospital.

(e) The Chief Executive Officer may give authority to one or more Medical/Professional Staff member(s) to make statements to the news media or public about matters brought before the Medical/Professional Staff. In the absence of such expressed authority, no one shall make statements on behalf of the Hospital to the news media or public.

8. Professional Conduct

The Hospital has zero tolerance for any abusive or unprofessional behaviour directed towards staff, Medical/Professional Staff members, Patients, or others. The policy is set out in the Hospital Policy Manual #9-257 Respectful Workplace Program and #9-404 Code of Behaviour: Respect in the Workplace as well as the Hospital's Code of Conduct. It is the Hospital's expectation that all Medical/Professional Staff members develop and maintain collegial and professional working relationships and treat all staff, Medical/Professional Staff members, Patients, and others with dignity.

9. Professional Staff Competency and Performance Issues

Any Medical/Professional Staff member or other person may advance a written complaint to the Chief Executive Officer, Chief of Staff, or Chief of Department concerning a Medical/Professional Staff member regarding an alleged violation of the By-law, Rules and Regulations, professional misconduct, incompetence, professional incapacity, unethical behaviour, or other conduct, giving reasonable cause for complaint. See Corporate Manual Policy # 2-340 Whistleblower Policy

10. Management of Patient Care and/or Behavioural Issues

(a) If any situation arises on any matter, including quality of care, Patient or staff complaints, on-call participation, staff supervision, staff responsibility or discipline, all personnel who become aware of such situation shall immediately notify the Chief of Department, who shall take any action they deem appropriate.

(b) Upon being notified of a situation, a Chief of Department may, in their discretion, contact the relevant senior responsible Medical/Professional Staff member(s) and/or the Chief of Staff, as necessary or appropriate, and shall, in any event, report to the Chief of Staff on any significant matters affecting any Department, Division, or Program or the Hospital as a whole.

11. Progressive Discipline

(a) Behaviour and quality of care occurs along a continuum, which ranges from exemplary to unacceptable.

(b) A staged approach is a progressive approach to managing problems in which the response is dictated by the trigger. The objective is to ensure that action is always taken when problems occur and that the response is useful and appropriate and facilitates improvement in health care delivery. The intention of this approach is remediation but it is critical to note that remediation will not work unless the individual in question accepts responsibility for their actions and acknowledges that they must make personal changes. It is important to note that the appropriate response to the unacceptable behaviour or Patient care will depend on the degree of egregiousness of the problem. Some single incidents may need to be escalated to Stage 2 or 3.

(i) **Stage 1**

(A) After an appropriate investigation has substantiated the complaint, a written apology may be required and reprimand will be noted in the personal (credentialing) file with copies to the Chief Executive Officer. The Medical/Professional Staff member will be advised that recurrent verified complaints will follow the stages of progressive discipline.

(ii) **Stage 2**

(A) Written reprimand with notice to the Medical Advisory Committee and may include loss of access to elective resources for up to 30 days and/or other action deemed appropriate by the Medical Advisory Committee.

(iii) **Stage 3**

(A) Mandatory assessment by the Ontario Medical Association Physician Health Program and/or report to the CPSO or similar process for the appropriate College as determined by the Chief of Staff and/or mid-term revocation of Privileges.

(c) Medical/Professional Staff members are referred to By-law, Articles 5 and 6.

12. Attendance

(a) Medical/Professional Staff members are required to meet the attendance requirements for Department and M/PSA meetings set out in the By-law, which is 50% of M/PSA meetings and 75% of Departmental meetings. If attendance at meetings falls below the requirements, the Medical Advisory Committee may require written reasons. The Medical Advisory Committee, at its discretion, may recommend to the Board that the delinquent Medical/Professional Staff member be disciplined, which could result in:

(i) excusing the Medical/Professional Staff member from attendance requirements; and/or

(ii) restriction of Privileges for a specified period of time; and

(iii) placing a letter on attendance in the Medical/Professional Staff member's file for consideration at the time of reappointment.

(b) If the Medical/Professional Staff member feels there is appropriate reason for lack of attendance, they may request to appear before the Medical Advisory Committee before the disciplinary action is implemented.

(c) Absence at Department, Division, Program, or M/PSA meetings, or any assigned committee meetings, will be excused at the discretion of the Chief of Staff in the case of:

(i) meetings or educational conference elsewhere;

(ii) emergency;

(iii) illness;

(iv) family illness;

(v) vacation;

(vi) emergency duty, call responsibilities; or

(vii) pre-assigned operating room/out-patient clinic schedules.

(d) Medical/Professional Staff member-initiated requests for yearly attendance exemptions from Department, Division, Program, or M/PSA meetings due to standard conflicts with the meeting schedule shall be submitted in writing and approved by the Chief of Staff on an annual basis, preferably at the time of making an application for reappointment.

(e) The Chief of Staff shall compile attendance data semi-annually and may provide notice letters to those Medical/Professional Staff members at risk of not meeting attendance requirements and may be subject to review by the Credentials Committee and/or the Medical Advisory Committee.

13. Continuing Education

(a) All Medical/Professional Staff members are to meet the requirements set by their applicable College.

(b) Failure to submit an education record and failure to comply with Rules and Regulations, Department, Division, or Program Rules and Regulations, and policy regarding continuing education may be grounds for refusal of reappointment.

(c) Some Departments, Divisions, or Programs may require subject-specific continuing education or may require a greater number of educational hours, as recommended by their individual Rules and Regulations or the Medical Advisory Committee.

(d) Active and Associate Medical/Professional Staff members must complete, appropriately document, and submit a minimum of 20 certified hours and 20 discretionary hours of CME per year at each annual reapplication.

(e) The CME hours used to meet the requirements in 13(d) may be a duplication of those used to meet applicable College requirements described in 13(a).

14. Monitoring of Associate Staff Members

(a) Physicians, Dentists, Midwives, and Registered Nurses in the Extended Class who are applying to the Active Staff, subject otherwise to the determination of the Board, will be assigned to the Associate Staff and work under the counsel and supervision of the Chief of Department or another Active Staff Medical/Professional Staff member named by the Chief of Department and assigned by the Medical Advisory Committee.

(b) If there is no appropriate Medical/Professional Staff member to act as supervisor, an alternative mechanism will be followed as approved by the Medical Advisory Committee.

(c) Both the Associate Staff member and the supervisor may request a change of supervisor once during the period of Associate Staff membership.

15. Duty of Supervisors of Associate Staff Members

(a) A supervisor assigned to an Associate Staff member shall:

(i) monitor the Associate Staff member’s performance of procedures and practice in the Hospital;

(ii) monitor the Associate Staff member’s records and work in order to evaluate the competence of the Associate Staff member;

(iii) guide and advise the Associate Staff member on the organization and procedures of the Medical/Professional Staff; and

(iv) encourage appropriate use of Hospital resources.

(b) A supervisor shall immediately inform the Chief of Staff, Chief of Department, and Chief Executive Officer of any evidence of incompetence on the part of the Associate Staff member.

16. Reports of Supervisors of Associate Staff Members

(a) At the end of six months and then again at the end of 12 months, the Chief of Staff and/or the supervisor(s) shall review all aspects of the Associate Staff member's work and conduct, and make a written report as to their views on the continuance of Privileges. The report may include:

(i) the number of Patients treated and procedures done by the Associate Staff member;

(ii) indications for and appropriateness of diagnosis and management;

(iii) comments on the Associate Staff member's quality of care and record keeping;

(iv) comments on the use of Hospital resources;

(v) comments on the Associate Staff member's ability to function in conjunction with other staff; and

(vi) input from other health team members.

(b) One month before application for Active Staff membership, the Associate Staff member shall provide written notice to the Chief of Staff of the intention so that the Chief of Staff may review with the supervisor(s) the Associate Staff member's performance and make written recommendations, taking into consideration the recommendations of the Chief of Department.

(c) The recommendations noted in (b) above will be forwarded to the Credentials Committee for review and recommendation to the Medical Advisory Committee and the Board.

17. On-Call Rota

(a) The Chief of each Department or Head of Division shall produce and post their respective monthly duty and on-call rosters at least two weeks before the first day of each month. Access to the Hospital's resources, including access to beds, operating rooms, and diagnostic Programs are contingent on each Medical/Professional Staff member providing their share of on-call coverage unless otherwise exempted.

(b) If a Medical/Professional Staff member wishes to withdraw, totally or partially, from the provision of on-call coverage, their access to Hospital resources will be reduced or discontinued.

(c) Each Physician, Dentist, and Midwife of the Active or Associate Staff shall participate in an on-call duty roster, unless otherwise exempt by the Chief of Department or Head of Division or Program in accordance with the on-call

Department or Program Rules and Regulations and policies approved by the Medical Advisory Committee. Courtesy Staff may also participate on the on-call duty roster subject to Department, Division, or Program Rules and Regulations. Each Active or Associate Staff Member must do a minimum of 75% of their portion of the on-call rota for their Department/Division. A maximum 25% of an Associate or Active Staff Member's share of the on-call rota can be covered by another appropriately credentialed member of the Medical/Professional Staff, whether they have Active, Associate, Courtesy, or Locum privileges.

(d) Prompt response for consultation requests is an expectation. On-call response times are outlined in the Consultant Coverage Responsibilities While On Call section of these Rules and Regulations, #33.

18. Clinical Procedures

Each Department, Division, or Program shall make recommendations to the Medical Advisory Committee regarding the clinical procedures to be performed in each Department, Division, or Program.

19. Viewing Operations or Procedures

Any aspect of Patient care or Medical/Professional Staff conduct, including any surgical, obstetrical, anaesthetic, or other procedure performed in the Hospital, may be viewed without the permission of the Medical/Professional Staff member performing the procedure by:

(a) the Chief of Staff or delegates who have the skill and experience with respect to the procedures to be viewed; and/or

(b) the Chief of Department or delegate.

20. Practice Review and Evaluation

Periodic peer review may be initiated at any time at the direction of the Medical Advisory Committee.

21. Professional Achievement Review

Every three years, the Chief of Staff shall conduct a Professional Achievement Review. The process shall include a personal interview with the Medical/Professional Staff member and the Chief of Department and a review of the following factors with each Medical/Professional Staff member:

(a) the type of application being made, including,

(i) application for reappointment; and

(ii) expansion of, or a change in, Privileges;

(b) if requested, a current, Certificate of Professional Conduct for Physicians, certificate of registration for Dentists and Midwives, or annual registration payment card for Registered Nurses in the Extended Class and a signed consent to the release of information for the registrar of the applicable College;

(c) the name of the Department, Division, or Program to which the application is being made;

(d) the category of Privileges requested;

(e) the procedures requested;

(f) the effect of appointments to other hospitals on the Medical/Professional Staff member's duty/obligations and quality of care provided at the Hospital;

(g) participation in continuing education programs;

(h) ability to communicate effectively with Patients and staff;

(i) on-call participation;

(j) staff and committee responsibilities;

(k) quality of care issues, including complications, infection rate, tissue and audit committee reports, utilization review, Patient outcomes, etc.;

(l) Patient/staff complaints;

(m) ability to supervise staff;

(n) monitoring of Patients;

(o) health record documentation;

(p) appropriate and efficient use of Hospital resources;

(q) a record of any criminal convictions;

(r) an authorization for the release of information, where appropriate;

(s) a willingness to participate in the discharge of Medical/Professional Staff member obligations;

(t) general compliance with the By-law and these Rules and Regulations, and confirmation that the applicant will continue to abide by them; and

(u) educational/teaching activities.

22. Enhanced Performance Review

Each Active Staff member will be required to undergo an EPR when there is a concern regarding professional competency and/or when requested by either the Chief of Staff or the relevant Chief of Department.

23. Leave of Absence

(a) A Medical/Professional Staff member may request a leave of absence of up to 12 months subject to the following:

(i) all requests shall be submitted, in writing, to the relevant Chief of Department, which shall include the reason for the request; and

(ii) the Chief of Department shall forward the request along with his/her recommendation to the Chief of Staff and Medical Advisory Committee;

(iii) in the event of a request related to an extended illness or disability of the member, the Chief of Staff shall approve the request upon recommendation of the Medical Advisory Committee; or

(iv) in other circumstances the recommendation of the Medical Advisory Committee and the Chief of Staff shall be forwarded to the Board for review and approval, if appropriate.

(b) Prior to returning from a leave of absence, the Medical/Professional Staff member may be required, by the Chief of Staff, to produce a medical certificate of fitness from a physician acceptable to the Chief of Staff. The Chief of Staff may consult with the relevant Chief of Department in determining an acceptable physician to issue the medical certificate of fitness to practice. The Chief of Staff may impose such conditions on the Privileges granted to such member as appropriate, which may include a probationary period.

(c) A member on a leave of absence may request an extension of the leave of absence, so long as the total leave of absence shall not be greater than 12 months. An application for extension shall be made at least 30 days prior to the end of the leave of absence.

(d) Leaves of absence longer than one year will require re-application for appointment to the Medical/Professional Staff in the manner and subject to the criteria set out in the By-law.

24. Probationary Period After Leave of Absence

(a) In the event of an absence of a member from clinical practice of more than six months and who is requesting a return to practice, the Chief of Department will:

(i) Present a recommendation to the Credentials Committee and to the MAC for approval by the Board outlining the plan, if any, for return to clinical practice. The plan may include a modification of privileges, a degree of review and/or a probationary period.

(ii) All documentation received during the performance review process will be maintained by the Chief of Staff.

(iii) Detailed information will be provided when exception to normal practice and procedure is recommended. This information should include documentation that the member can meet appropriate standards of care, assurance that action is taking place to ensure that the exception will not be continued beyond a reasonable time, and that the member is providing an essential service.

(b) At the conclusion of any probationary period, a report will be prepared that includes details of:

(i) clinical activity during the interval;

(ii) clinical and technical competence;

(iii) skills and contributions;

(iv) professional attitude and interpersonal skills;

(v) personal and professional integrity;

(vi) attendance at required meetings, contributions to staff, committee activities;

(vii) Patient concerns/complaints; and

(viii) a recommendation from the Chief of Department regarding reappointment to the Medical/Professional Staff.

(c) The Credentials Committee, after considering all information, may then advise the Medical Advisory Committee that the Medical/Professional Staff may:

(i) resume clinical practice with former Privileges; or

(ii) resume clinical practice with restricted Privileges; or

(iii) continue probationary activity for six to 12 months followed by further review; or

(iv) be denied reappointment.

25. Pregnancy/Parental Leave

(a) Pregnancy/parental leave benefits for Medical/Professional Staff members who are employees of the Hospital are outlined in the relevant employee policies, as amended from time to time.

(b) Medical/Professional Staff members who are not employees of the Hospital may request pregnancy/parental leave by applying for a leave of absence and, if approved, will:

(i) not be required to serve on-call;

(ii) arrange for coverage of in-Patients during the leave; and

(iii) completely cease clinical activity at the Hospital.

(c) The Medical/Professional Staff member and Hospital leadership will endeavor to work together to arrange for coverage of the Medical/Professional Staff member's Hospital responsibilities.

(d) When coverage is intended to be provided by a Physician/Dentist/Midwife who is not a Medical/Professional Staff member, the following will apply:

(i) the Physician/Dentist/Midwife will apply for Locum Tenens Staff Privileges; and

(ii) if granted such Privileges, the Physician/Dentist/Midwife is expected to fulfill the role of the Medical/Professional Staff member in all clinical respects unless alternative, mutually agreeable terms of service have been developed.

(e) A Medical/Professional Staff member on pregnancy/parental leave will be expected to return to the same clinical duties and the same access to resources that were in place at the commencement of their leave unless the Medical/Professional Staff member wishes to negotiate alternative, mutually agreeable terms of service.

(f) Should circumstances arise before, during, or after the leave that may impact the clinical duties and/or access to resources, effort will be made to include the Medical/Professional Staff member in relevant discussions.

26. Locum Tenens

(a) Every Medical/Professional Staff member who wishes their practice at the Hospital to be covered by a Locum Tenens Staff member shall submit the request to the Chief of Staff and the Medical Advisory Committee at least 30 days in advance, to allow sufficient time to have the Locum Tenens' credentials evaluated. In emergency situations, temporary Privileges can be granted by the Chief Executive Officer in accordance with the By-law.

(b) Unless otherwise stipulated by the Medical Advisory Committee, a Locum Tenens Staff member's Privileges will be in effect only for the duration of the defined locum period.

(c) Granting of Locum Tenens Staff Privileges provides no preferential access to any other Privilege appointment at some later time.

27. Notice of Resignation

Every Medical/Professional Staff member shall give written notice of resignation to the Chief of Staff and their Chief of Department or Program Head at least three months before their departure.

28. Privileges for Transplant and Transport Teams

(a) The physician members of transplant teams coming from outside the Hospital will be deemed to be granted temporary Privileges for the removal of organs when their presence has been requested through the Trillium Gift of Life Program.

(b) The procedure to be followed will be as outlined in the Interdisciplinary Clinical Manual – #3-68 Organ and Tissue Donation, and include:

(i) ascertaining that consent for removal of the organ has been received from the next of kin; and

(ii) informing the administrator-on-call of the pending organ retrieval.

29. Medical Advisory Committee and Subcommittees

(a) The Medical Advisory Committee is composed of Medical/Professional Staff members as set out in the By-law, and it shall make recommendations to the Board on those matters under its purview. The Chief Executive Officer and Chief Nursing Executive or respective delegates shall attend meetings of the Medical Advisory Committee without the power to vote, and they shall receive notice of these meetings.

(b) Medical Advisory Committee subcommittees are those subcommittees of the Medical Advisory Committee that are established in accordance with the By-law.

(i) The Medical Advisory Committee subcommittees are:

(A) Code Blue Committee;

(B) Credentials Committee;

(C) Infection Prevention and Control Committee;

(D) Medication and Therapeutics Committee; and

(E) other subcommittees as determined by the Board.

(ii) Accountability

(A) Medical Advisory Committee subcommittees are accountable to the Medical Advisory Committee.

(iii) Appointment to Medical Advisory Committee subcommittees

(A) The Medical Advisory Committee will appoint the members of each subcommittee. Normally members will be appointed for a three-year term.

(B) All membership appointments will be reviewed and confirmed by the Medical Advisory Committee on an annual basis.

(C) All Medical/Professional Staff members are eligible for appointment to a Medical Advisory Committee subcommittee.

(D) The Chief of Staff will be an ex-officio voting member of each subcommittee, and have the power to send a voting delegate to a meeting.

(E) In the event of a vacancy on a subcommittee, the Medical Advisory Committee may appoint a replacement to complete the remainder of the term.

(iv) Appointment of Chair of Medical Advisory Committee Subcommittees

(A) The Medical Advisory Committee will appoint the chair of each subcommittee.

(v) Duties of the Chair of a Medical Advisory Committee Subcommittee

(A) The chair of a subcommittee:

i. will call meetings of the subcommittee;

ii. will chair the subcommittee meeting;

iii. at the request of the Medical Advisory Committee, will discuss all or part of any report of the subcommittee; and

iv. may request meetings with the Medical Advisory Committee.

(vi) Medical Advisory Committee Subcommittee Requirements

(A) In addition to the specific duties of each subcommittee, all subcommittees will:

i. hold the number of meetings specified in their terms of reference;

ii. circulate copies of the minutes to the members of the subcommittee, and to the Medical Advisory Committee as appropriate;

iii. where a subcommittee wants to make a recommendation to the Medical Advisory Committee, prepare a written report, including any recommendations and forward it to the Medical Advisory Committee; and

iv. maintain a record of attendance of subcommittee members.

(vii) Medical Advisory Committee Subcommittee Powers and Duties

(A) Each subcommittee will:

i. Recommend to the Medical Advisory Committee matters that fall within their area of responsibility and recommend changes and/or amendments to the Rules and Regulations.

ii. Have the right to conduct a review of any health record, when required to fulfill its duties and functions; and

iii. Review matters within its area of responsibility or are referred by the Hospital administration and/or the Medical Advisory Committee and report to the Medical Advisory Committee as may be required or considered advisable.

MEDICAL/PROFESSIONAL STAFF ASSOCIATION MEETINGS

30. Order of Business at M/PSA Meetings

(a) The order of business at the annual meeting of the M/PSA shall be held in conformity with the *Public Hospitals Act* and the By-law and shall include at least:

(i) minutes of the previous annual meeting;

(ii) report from the President of the Medical/Professional Staff Association;

(iii) report from the Treasurer and approval of budget and annual dues;

(iv) report of the Medical Advisory Committee, with recommendations for improvement of the professional work of the Hospital based on the work done and results obtained during the past year; and

(v) reports, nominations and election of the elected members of the Medical/Professional Staff Association Executive; and

(vi) report from the Chief Executive Officer, Chief Nursing Executive and Chief of Staff.

(b) The order of business at a regular meeting of the M/PSA shall be held in conformity with the *Public Hospitals Act* and the By-law and shall include at least:

(i) minutes from the previous meeting;

(ii) business arising from the minutes, and unfinished business;

(iii) report from the President, followed by the Secretary and then Treasurer of the Medical/Professional Staff Association;

(iv) relevant reports from committees and departments;

(v) report from the Chief Executive Officer, Chief Nursing Executive and Chief of Staff;

(vi) report of the Medical Advisory Committee which shall include recommendations for the improvement of the professional work of the Hospital and which may include reports from any standing or special committees; and

(vii) conclude with any other business that has arisen.

(c) Procedures for the order of business as a special meeting of the M/PSA are described in the By-law.

31. Quorum

(a) A quorum is the number of Medical/Professional Staff members required to carry on business for a meeting of the M/PSA.

(b) The lesser of 25% or 30 members of the Medical/Professional Staff Association entitled to vote and present in person shall constitute a quorum at any meeting of the M/PSA.

(c) In any case where a quorum of the M/PSA has not arrived at the place named for the meeting within 30 minutes after the time named for the start of the meeting, those Medical/Professional Staff members who have presented themselves shall be given credit for their attendance at the meeting for the purpose of satisfying the attendance requirements of the By-law.

PATIENT CARE RESPONSIBILITIES

Chains of command, supervision of care, and other matters are essential to assurance of continuing quality Patient care, with effective, inter-professional, Patient and family communication.

32. On-Call Guidelines for Physicians, Dentists, and Midwives

(a) All Active and Associate Staff Physicians/Dentists/Midwives shall, with peers, participate in the on-call roster for their specialties, unless exempted.

(b) Expectations regarding on-call coverage are as outlined below in the Consultant Coverage Responsibilities While On Call section of these Rules and Regulations, #33.

(c) Each Medical/Professional Staff member of a call-group of five or more Medical/Professional Staff members must do a minimum of 70% of their portion of the on-call rota. That is, a maximum of 30% of a Medical/Professional Staff member's on-call rota can be given away. Only 10% of a Medical/Professional Staff member's total on-call duties can be given to one or more locum(s). Any additional reduction in a Medical/Professional Staff member's share of the on-call rota must go to an Associate or Active Staff member. Such requirements shall be calculated over a rolling six-month period.

(d) In some specialty groups, on-call rosters may be regional.

(e) Some specialties may set on-call roster guidelines differing from the above; any such alternative arrangement must be approved by the Medical Advisory Committee.

(f) Any alteration to on-call responsibilities within a Department must be coordinated and sanctioned by the Chief of Department. Any alteration approved by the Chief of Department does not negate the obligation set out in (a) above where Program need is identified. Major changes will be approved by the Chief of Staff.

(g) Any Medical/Professional Staff member previously exempt from on-call obligations, who is required to return to on-call responsibilities, shall where necessary undertake renewed training and experience in order to meet such obligation.

(h) A copy of the on-call schedule must be sent to:

  (i) switchboard; and

  (ii) the Medical/Professional Staff members involved.

(i) Switchboard will forward all call schedules and updates to the Emergency Department and the original and final call schedules for each month to the Chief of Staff's office.

33. Consultant Coverage Responsibilities While On Call

The goal is to establish guidelines that enhance the delivery of quality Patient care by minimizing the amount of time that Patients and referring Medical/Professional Staff members are required to

wait for consultant Programs. A successful outcome will be achieved through a collaborative effort from both the referring and consulting Medical/Professional Staff member.

(a) Communication

The referring Medical/Professional Staff member (or non-member Registered Nurse in the Extended Class or physician assistant) shall speak directly with the consultant on call for the specific Program, which is deemed most appropriate, to convey pertinent details of the Patient's condition and urgency of the consultation. If agreement cannot be reached, the referring Medical/Professional Staff member's request for consultation will be honoured in the primary interest of Patient care.

(b) Response Times

All on-call consultants must respond to requests for their Programs:

(i) In life and limb threatening situations a stat call will be initiated. Telephone response is required within 15 minutes and on-site presence is required within 30 minutes.

(ii) In all other circumstances, telephone response is within 15 minutes to a maximum of 30 minutes from the time the call was made and physical presence within 60 minutes or other decision for disposition of Patient.

Exceptions:

If the "on-call" consultant is busy performing a procedure, a designate must return the call and speak with the referring Medical/Professional Staff member to assess the nature of the case. If the Patient's condition is deemed life or limb threatening, an alternate Medical/Professional Staff member from that specialty shall be identified and contacted.

These criteria may not be able to be met 100% of the time due to factors outside of the Medical/Professional Staff member's control, such as inclement weather, competing emergencies, and being involved in providing care to another acute Patient. This does not remove the obligation to provide prompt telephone response indicating estimated time of arrival.

(c) MRP and Transfer of Care Guidelines

If any Patient requires admission, the referring Medical/Professional Staff member will communicate that fact along with the appropriate clinical details to the consulting Medical/Professional Staff member who, upon acceptance, will become the MRP. Some referring Medical/Professional Staff members may, after discussion with the MRP, provide temporary holding orders. However, as of that time, clinical responsibility for the Patient will be transferred to the MRP; See Corporate Manual Policy #2-409Most Responsible Practitioner Status.

After a consultant has assessed the Patient and if the consultant feels that the Patient requires to be seen by another appropriate consulting Program, the initial consultant shall write or dictate a note of their clinical assessment on the health record and make all efforts to contact the appropriate consulting Program,. Under certain circumstances, the first consultant may request the referring Medical/Professional Staff member's assistance in expediting referral to another Program, while they attend to their own Patients requiring immediate attention.

(d) Disagreement & Code of Conduct

Disagreements between the referring Medical/Professional Staff member and the consultant on-call shall be handled with courtesy, respect, and dignity for one another. Medical/Professional Staff members must refrain from disagreements with each other in work areas that may be overheard by Patients, visitors, employees, or other individuals. Physicians must also refrain from conduct which may reasonably be considered abusive or threatening, whether the threat is expressed or implied. See Corporate Policy Code of Conduct

If the involved parties cannot resolve the issue then the following will be contacted in the order outlined:

(i) Chief of the consultant Program,

(ii) Chief of the referring Program, if no resolution then

(iii) Chief of Staff.

(e) Surveillance

A process identifying the consultant's response time and conduct shall be implemented and monitored. An on-call audit trail for responsibility and complaints shall be utilized as one of the factors for Medical/Professional Staff members' performance evaluation during the process of annual reappointment.

(f) Consequences of Failure to Comply

Medical/Professional Staff members, both referring and consulting, who do not act in accordance with this policy and standards of conduct shall be subject to disciplinary action as outlined in the By-law and these Rules and Regulations.

(g) Recommended Actions

Any perceived breach of this rule shall be reported to the Chief of Staff in writing. The Chief of Staff will meet the Medical/Professional Staff member and the respective Chief to address the issues raised.

34. Most Responsible Physician/Dentist/Midwife

(a) There will be only one Physician, Dentist, or Midwife at any one time referred to as the MRP/D/M for each Patient.

(b) The identity of the MRP/D/M must be clearly discernible in the health record from the time of admission to the time of discharge.

(c) The admitting Medical/Professional Staff member assumes the role of the MRP/D/M unless they transfer that role to another Medical/Professional Staff member.

(d) Transfer of the MRP/D/M status from one Medical/Professional Staff member to another must be written in the orders with date and time. Before this transfer of responsibility, verbal communication between the Medical/Professional Staff members involved must occur to ensure continuity of care.

(e) If a transfer occurs, documentation of the care that has been given to point of transfer shall be made on the health record by the transferring Medical/Professional Staff member.

(f) See Corporate Manual Policy– #2-409 Most Responsible Practitioner (MRP) Status.

35. Rules for the Most Responsible Physician, Dentist, or Midwife

The MRP/D/M shall:

(a) provide daily care to the Patient and communicate with the care team on a daily basis (or as appropriate);

(b) respond by telephone promptly (within 30 minutes) for continuing medical problems.

(c) maintain communication with Medical/Professional Staff member(s) on-call for them;

(d) come to the unit to clinically assess new urgent problems;

(e) maintain either verbal or written active communication with the other Medical/Professional Staff members also on the case;

(f) communicate with the family; and

(g) write progress notes to accurately reflect the clinical condition of the Patient. This will vary from several times a day to daily. (See Progress Notes.)

36. Residents

(a) Residents perform medical acts in a graded and progressive fashion. They are directed, supervised, and controlled through more senior Residents. At all times, accountability for the Resident's actions is the responsibility of the MRP.

(b) Medical/Professional Staff members are responsible and accountable for all procedures done by Residents.

(c) In addition to the above, the guidelines for the supervision of Residents, as approved from time to time by the Medical Advisory Committee, the CPSO, and the respective faculty of health sciences of the Resident, shall be followed.

(d) Residents do not require countersignature of orders.

(e) A Resident must notify the MRP if:

(i) a Patient is admitted to the MRP for either elective or emergent purposes;

(ii) there is any significant change in the Patient's condition;

(iii) there is any unusual or unexpected finding;

(iv) the diagnosis or management is in doubt;

(v) they are going to perform a procedure that has the potential for immediate or future serious morbidity;

(vi) a Patient is going to be discharged from an Emergency Department, ambulatory setting, or in-patient Program, unless such discharge has been previously approved either for that particular Patient or for a category of Patients for which the Residents has demonstrated competence;

(vii) there are any requests by the Patient and/or relative; and

(viii) there are any requests to do so by a nurse or Emergency Department Physician or other Medical/Professional Staff member.

(f) It is noted that in certain emergency situations, prior notice may not be possible.

(g) The notice to the MRP will be documented in the health record by the Resident.

37. Undergraduate Medical and Midwifery Students

(a) Clinical clerks are undergraduate medical or midwifery students registered in an approved medical school or midwifery education program who are not licensed in Ontario to practice medicine or midwifery but have received sufficient training to allow them to perform certain duties as specifically assigned by their supervisors.

(b) Clinical clerks may carry out care of Patients with the MRP/M's approval and supervision.

(c) Undergraduate medical and midwifery students may communicate with and examine Patients under supervision and with Patient's consent, but take no independent part in Patient care.

(d) Clinical clerks perform medical acts on a graded progression supervised and controlled through more senior trainees up to and including the MRP/M.

(e) All procedures performed by undergraduate medical or midwifery students must be done under the supervision of a Resident or Medical/Professional Staff member.

(f) All clinical clerk orders and notes must be signed with the designation of CC (clinical clerk) and must indicate authorization by a Resident or Medical/Professional Staff member, before the execution of the order. Orders must be legible. The name of the clinical clerk shall be printed next to the signature.

(g) All undergraduates' credentials must be verified and approved by the Chief of Staff and the Chief Executive Officer.

38. Admissions

(a) Only Physicians, Dentists, or Midwives who are Medical/Professional Staff members and who have admitting Privileges may admit Patients to the Hospital.

(b) No Patient shall be admitted to the Hospital until a diagnosis has been stated.

(c) The Physician, Dentist, or Midwife on-call for each Department, Division, or Program must be available and willing to respond in a timely fashion to see or accept responsibility for Patients in the Emergency Department at the request of the Emergency Medical/Professional Staff member.

(d) Within 24 hours of a Patient's admission to the Hospital, the MRP/D/M will prepare a record of the medical history and physical examination, which includes the Patient's medical history, physical examination, and a diagnosis. The report must be dated and authenticated by the MRP/D/M. Discharge planning is an important aspect of any admission and an expected date of discharge should be documented as soon as reasonably foreseeable.

(e) Prior to the admission of a Patient with a known or suspected condition that requires contact, airborne, or droplet precautions, the MRP/D/M shall notify the relevant Hospital staff.

(f) Physicians, Dentists, or Midwives admitting Patients shall be held responsible for giving such information as may be necessary to assure the protection of other Patients, employees, and other staff from those who are a source of danger from any cause whatsoever or to assure protection of the Patient from self-harm. If the

admitting Physician, Dentist, or Midwife has a reason to believe that the Patient may, in spite of usual or necessary precautions, be a threat to themselves or to others, then the MRP/DM shall identify and manage the Patient as per Hospital protocol.

(g) Admissions must be made under one named MRP/D/M.

(h) Emergency admissions to the Hospital are through the Emergency Department unless other policy arrangements are established.

(i) If the admitting Medical/Professional Staff member is not the MRP/D/M, direct member to member communication and agreement must precede admission. If the MRP/D/M identified has not assessed the Patient within 16 hours of admission, the Chief of the relevant Department shall be notified.

(j) When an elective admission arrives on the in-patient unit, the nurse in charge will notify the MRP/D/M (or Resident) and record this on the clinical notes.

(k) Pre-admission history, including diagnosis and physical examination documentation, will be considered acceptable for the Patient's current encounter, if it has been performed within 30 days of the admission date. Documentation beyond 30 days must be reviewed by the authoring Medical/Professional Staff member, updated to reflect any change in clinical condition, dated, and signed. The prenatal record shall be included as part of the chart for any obstetrical Patient.

(l) Following admission, a record of the admission will be available to the Patient's family physician if one can be identified.

39. Emergency Department

(a) The Chief of the Department of Emergency Medicine shall be responsible for the medical staffing of the Emergency Department.

(b) The Physician on duty is ultimately responsible for all Patients within the Emergency Department regardless of the severity of the presenting complaints unless a physician in the community has arranged a consultation with a Medical/Professional Staff member beforehand and such Medical/Professional Staff member is readily available to take responsibility for the Patient.

(c) Registered Nurses in the Extended Class on duty will be responsible for assigned Patients within their scope of practice.

(d) If the Patient has had an arrangement made for admission by an admitting Physician, Dentist, or Midwife, the responsibility will immediately pass to the admitting Physician, Dentist, or Midwife. The MRP/D/M, if they are the first provider seeing the Patient capable of making a disposition decision, must document their Patient assessment time (Physician/Provider Initial Assessment – PIA) on the Emergency Department record.

(e) Emergency Patients are the responsibility of the duty emergency Physician and the duty emergency Physician may see any Patient in the Emergency Department, including direct consults at their discretion if the clinical situation warrants.

(f) If the Patient is deemed to need specialized care:

(i) The specialist appropriate for that Program will be consulted and must respond within the appropriate length of time as mandated in the Consultant Coverage Responsibilities While On-Call section of these Rules and Regulations, #33.

(ii) If the consultant on-call has not responded, then the emergency Physician and the appropriate Chief of Department must be advised. If the Chief of Department is not available, the Chief of Staff must be advised.

(iii) Consultants must document their Patient assessment times in the Emergency Department record.

(g) If a Patient needs an admission, the staff Physician/Dentist/Midwife will be responsible for the admission, unless by mutual agreement, the emergency Physician agrees to provide holding orders.

(h) The consultant or the emergency Physician may discharge the Patient from the Emergency Department with instructions for care or follow-up as appropriate. Emergency Physicians are advised to discuss this discharge with the consultant before discharge.

(i) The emergency Physician has final authority on the disposition of the Patient.

(j) No Physician, Dentist, or Midwife shall order the admission of a person to the Hospital unless, in their opinion, it is clinically necessary that the person be admitted.

(k) In any case of disagreement over Patient care in the Emergency Department, the emergency Physician has responsibility for obtaining care and making arrangements, with appeal to the appropriate Chief of Department(s). If the Chief of Department is unable to resolve the issue then it will be referred to the Chief of Staff.

(l) Emergency Physicians will document time of Patient contact and time of Patient disposition decision. Consultants will document time of consult and disposition decision.

40. Care in the Intensive Care Unit

(a) Medical/Professional Staff coverage for the ICU shall be provided by the appropriate specialist privileged to provide ICU care.

(b) When a Patient is transferred to the ICU, the intensive care Physician has responsibility for the direct supervision and management of their Patients in the ICU and is designated the MRP during this period.

41. Communication

(a) At the time of Patient rounds and on a regular basis, the MRP/D/M will discuss the Patient's illness and progress with the Patient.

(b) When the Patient cannot comprehend the explanation, the MRP/D/M shall make every reasonable attempt to discuss the condition of the Patient with the next of kin or substitute decision maker on a regular basis and/or use language translation services when appropriate.

(c) The MRP/D/M shall be expected to respond to all reasonable requests from the named next of kin or substitute decision maker for information on the Patient's care and progress.

(d) If multiple next of kin wish information, they will be required to name a spokesperson or arrange a "family conference" to obtain the information.

(e) If a Patient's condition deteriorates significantly, the nursing staff will inform the family and suggest that they attend the Hospital and speak with the MRP/D/M involved.

(f) The MRP/D/M may elect to make the call to the family about the Patient's changed condition.

(g) The nursing staff shall make every reasonable effort to assist the next of kin or substitute decision maker in contacting the MRP/D/M or a learner.

(h) Where possible, the Patient and family will be involved in the discussions and arrangements for the Patient's discharge from the Hospital or transfer to another health care facility.

(i) For cases where the Patient has been determined incapable, the substitute decision maker, in accordance with the *Consent and Capacity Act* shall receive all communication as contemplated by this section, and where necessary, provide consent consistent with the Hospital's Consent Policy. Consent to Treatment #3-100

(j) The content of such discussions must be documented by the MRP/D/M on the health record.

(k) The family physician or the MRP/D/M post-discharge must be made aware of the care requirements of the Patient by the discharging Physician at the time of discharge.

42. Allergies

(a) The MRP/D/M is responsible for identifying/reviewing the Patient's allergies on presentation.

(b) The MRP/D/M is responsible for documenting new allergies identified during the course of the Patient's care and any change in the status to a previously identified allergy.

43. Goals of Care for Life-Sustaining Treatment

(a) The MRP/D/M is responsible for implementing the specifics of the Patient's choice for goals of care for life-sustaining treatment as determined through discussion with the Patient, family, and/or substitute decision maker, or as written in the Patient's advanced care plan.

(b) The MRP/D/M or Medical/Professional Staff member consultants will record a summary of their discussions with the Patient, family, and/or substitute decision maker in the health record.

(c) The MRP/D/M is responsible for writing the orders for goals of care for life-sustaining treatment on the health record using the pre-printed form only after discussion with the Patient or substitute decision maker.

(d) Orders for the withholding of cardiopulmonary resuscitation will be removed at any time upon request of the Patient or substitute decision maker where the Patient is not competent.

(e) It is the responsibility of each Medical/Professional Staff member to be familiar with the Interdisciplinary Clinical Manual- #3-165 Goals of Care: Plans for Life-sustaining Treatments.

44. Organ Donation

It is the responsibility of each Medical/Professional Staff member to be knowledgeable about the Hospital's policies and procedures on organ and tissue donations. Interdisciplinary Clinical Manual – #3-68 Organ and Tissue Donation.

45. Consultations

(a) Consultations may only be requested with the knowledge and consent of the MRP/D/M, except as provided in the *Public Hospital Act*.

(b) The Physician, Dentist, or Midwife on-call for each Department, Division, or Program must be available and willing to respond in a timely fashion to see Patients in the Hospital and in consultation at the request of the attending Physician, Dentist, Midwife, a member of the Extended Class Nursing Staff or an employed Registered Nurse in the Extended Class.

(c) Direct Medical/Professional Staff member to Medical/Professional Staff member communication outlining the reason for the consultation and the conditions relevant to such requests must be clearly stated.

(d) The Patient and/or substitute decision maker must be informed of the requested consultation and its significance.

(e) The health record must contain a note about the consultation and the expectations relating to it (e.g. opinion, advice, treatment changes, management of a segment of the care, etc.).

(f) The consultant will normally, except by prior arrangement, visit the stable Patient within 24 hours of receiving the request.

(g) "It is the expectation that when a consultation is requested for a patient admitted to CMH, the consultation will be conducted in person when services are available locally. For regional services, the patient may need to be transferred or the physician should be required to come on site and in person for the assessment. Any initial telephone specialist support and advice should be supplemented with an in person assessment of the patient and documented in the chart appropriately (by initial specialist contacted or equivalent physician specialist)."

(h) Immediately following a review of the health record and an examination of the Patient, the consultant will write a report on the health record, which contains an opinion and specific recommendations for care. This written note will be followed by a full dictated note.

(i) Midwives are responsible to initiate a consultation as described in the College of Midwives Indications for Mandatory Discussion, Consultation and Transfer of Care.

(j) Physicians shall accept consultations for Patients of Midwives in accordance with Policy # 3-301 Midwifery Indications for Consultation/Transfer of Care and # 1-307 Midwifery Community Standards policy outlining requirements for mandatory consultation by a Physician.

46. Transfer of Care

(a) Each Medical/Professional Staff member will provide coverage for their Patients by being available or having a qualified substitute with whom prior arrangements have been made. These prior arrangements can include, as appropriate, the daily on-call Physician, Dentist, and Midwifery rosters for the Program. Medical/Professional Staff members are responsible for ensuring that in-Patients for whom they are the MRP/D/M have 24-hour coverage and are responsible for ensuring that the Hospital has access to that information and documentation.

(b) A Medical/Professional Staff member with admitting Privileges who expects to be unavailable will ensure that there is a Medical/Professional Staff member available at all times to assume responsibility for the care of their in-Patients for whom they are the MRP/D/M.

(c) When such substitution is to cover a period greater than 96 hours, the responsibility for Patient care must be transferred to another Medical/Professional Staff member who has agreed to accept responsibility.

(d) Transfer of care may also occur not only as a result of Medical/Professional Staff substitutions, but also as a result of changing Patient needs, or as a result of the movement of a Patient between different areas or units.

(e) For transfer of care, the following sequence of events must occur:

(i) The Medical/Professional Staff member transferring care must communicate with the Medical/Professional Staff member assuming the care of the Patient.

(ii) The Medical/Professional Staff member transferring care must give a clear order on the health record indicating the name of the Medical/Professional Staff member to whom the Patient was transferred.

(iii) The Medical/Professional Staff member assuming the care of the Patient must give an order that the care of the Patient is accepted and that the health record reflects this change. Alternatively, when communication between the transferring and receiving Medical/Professional Staff member has occurred, the Medical/Professional Staff member transferring care may write an order that the receiving Medical/Professional Staff member has agreed to accept the care of the Patient and that the health record shall similarly reflect this change. Transfer of care will not occur unless an order for the acceptance of the transfer of care is given.

(iv) The Medical/Professional Staff member transferring care must notify the Patient.

(v) Until notice and acceptance of the Patient is confirmed by the accepting Medical/Professional Staff member, the responsibility for the Patient remains with the transferring Medical/Professional Staff member, including care and documentation in the health record.

(f) On transfer of the Patient from one area to another when care is assumed by another Program, a transfer summary of the Patient's course will be prepared and accompany the Patient at time of transfer.

(g) Where a Medical/Professional Staff member has accepted responsibility for a Program, and believes it would not be appropriate to provide care for a specific Patient admitted to that Program, the Medical/Professional Staff member will

record in the health record the reasons for that decision. They will prepare an order to transfer the care to an alternate Medical/Professional Staff member, and acceptance of that transfer by the alternate will be noted.

(h) Questions about transfer of care will be referred to the Chief of Department.

(i) For Midwives, in accordance with the College of Midwives Indications for Mandatory Discussion, Consultation, and Transfer of Care, it is the responsibility of the Midwife to find a Physician who agrees to accept transfer of care of the Patient. In emergency circumstances, the obstetrician on-call will accept transfer of care of the Patient.

47. Discharge

(a) Patients shall be discharged on the written order of the MRP/D/M.

(b) Discharge orders should normally be written on the day before discharge and if possible 48 hours before discharge.

(c) At the time of discharge, the MRP/D/M will ensure that a discharge order has been written.

(d) On discharge of the Patient, the MRP/D/M shall be responsible for the completion of the health record and for the provision of a discharge summary, including medication reconciliation, in accordance with Hospital policy. Best practice supports the discharge summary to be completed on the actual date of discharge.

48. Discharge Against Professional Advice

(a) When a Patient insists upon leaving the Hospital against the advice of the MRP/D/M, the Patient shall be advised of the consequences of leaving. If the Medical/Professional Staff member is present, a statement describing the circumstances shall be entered by the Medical/Professional Staff member in the health record; where the Medical/Professional Staff member is not present, a statement describing the circumstances shall be entered by a nurse in the health record and the MRP/D/M shall be informed. Whenever possible, the Patient shall be asked to sign a release form.

(b) The MRP/D/M shall write or provide a verbal order to discharge the health record and be responsible for the completion of the discharge summary.

49. Coverage Arrangements During Suspension of Privileges

A Medical/Professional Staff member whose admitting Privileges have been suspended shall immediately transfer care of all Patients for whom they are MRP/D/M to another qualified Medical/Professional Staff member who can assume care as MRP/D/M and the suspended member shall be required to arrange with another Medical/Professional Staff member to admit and assume responsibility for care of any Patient for whom admission is sought during any such suspension. If

such arrangements cannot be expeditiously made then the Chief of Department will assume care of all affected Patients and/or delegate such MRP/D/M responsibilities to other members of the Department.

50. Coverage Arrangements During Vacation, Extended Leave of Absence or Interruption of Clinical Services

Each Medical/Professional Staff member is responsible for providing coverage for any vacation, an extended leave of absence or an interruption of clinical services and transfer care of all Patients for who they are MRP/D/M to another qualified Medical/Professional Staff member who can assume care as MRP/D/M.

51. Quality and Risk Management

(a) Each Medical/Professional Staff member will participate in quality and risk management programs under the direction of their Chief of Department and as approved by the Medical Advisory Committee.

(b) Each Medical/Professional Staff member will report to their Chief of Department any serious complication(s) of treatment or intervention(s) to a Patient under their care. Each Medical/Professional Staff member will also report to their Chief of Department, circumstances surrounding any unexpected death. For any event involving the Chief of Department, the Chief of Department shall directly report to the Chief of Staff.

52. Code of Conduct

(a) Medical/Professional Staff members are expected to treat staff, colleagues, and all others with respect and dignity, in accordance with the Hospital's mission, vision, and values.

(b) If conflicts arise, they should be addressed by the individuals in a professional manner. If no resolution occurs, the matter shall be taken to the Chief of Department for review and assistance with resolution. The Chief of Department shall prepare a written summary to the Chief of Staff.

(c) Medical/Professional Staff members are referred to the Corporate Manual Policy - #9-257 Respectful Workplace Program and #9-404 Code of Behaviour: Respect in the Workplace and #2-340 Whistleblower Policy and the Hospital's Code of Conduct document.

53. Geographic Area

A Medical/Professional Staff member shall not restrict or refuse the provision of Hospital services that are funded by the Ministry of Health and Long Term Care to an individual, directly or indirectly, based on the geographic area in which the person resides in Ontario.

HEALTH RECORDS AND DOCUMENTATION

54. Compliance with Health Information Management Policy and Procedure

(a) The health record provides a medium for documentation relating to health care, treatment, assessment, examination, or investigation of a Patient.

(b) All Medical/Professional Staff members must be familiar and comply with the Hospital's Health Information Management policies and procedures on health records. Corporate Manual Policy#12-34 Health Record Completion.

55. Content

(a) All health records and other documentation shall accurately reflect and describe the specificity and complexity of all diseases or conditions affecting a Patient and shall accurately describe all procedures performed during the Patient's stay/visit.

(b) The health record shall contain sufficient information to indicate what progress was made by the Patient, what problems had developed with the Patient, the assessment of the problems, their severity, the care that was rendered, and the outcome after treatment.

(c) Medical/Professional Staff members shall not use dangerous abbreviations and shall be familiar with and follow recommendations in the Hospital's Corporate Manual Policy #12-10 Corporate Abbreviations.

56. Responsibility for Completion

(a) The admitting Medical/Professional Staff member shall be responsible for documenting the Patient's medical history, the results of the physical examination, and the diagnosis of the Patient's medical condition upon admission.

(b) Each Medical/Professional Staff member shall be responsible for documenting the portion of the Patient care that they have rendered.

(c) Completion of Locum Tenens health records shall be the responsibility of the Locum Tenens. If the Locum Tenens is unavailable or unable to complete health records the Medical/Professional Staff member whom the Locum Tenens has replaced will be responsible. In the circumstance of a temporary practitioner they shall be responsible for their health record completion.

57. Time for Completion

(a) Concurrent documentation by all Medical/Professional Staff at the time of the event is expected.

(b) It is the Medical/Professional Staff member's responsibility to attend the Health Information Management Department to complete records. All in-Patient and out-

Patient health records should be completed as soon as possible and in accordance with the Health Records Completion Policy. Corporate Manual Policy #12-34 Health Record Completion.

(c) Where a Medical/Professional Staff member has a health record outstanding over 15 days, they are subject to procedures outlined in the Health Record Completion Policy. Timelines will be adjusted to reflect absences due to vacation, illness, etc.

(d) MRP/D/M will be notified of any incomplete chart that is outstanding beyond 15 days. There will be telephone notification of any incomplete chart at 60 days. There will be a 48 hour suspension of privileges for any incomplete chart beyond 90 days and notification of suspension to the Medical/Professional Staff member's College.

58. Disclosure and Removal of Health Record

(a) All health records are the property of the Hospital. Medical/Professional Staff members shall not remove health records (or notes, records, diagnostic tests, or other material relating to Patient care) from the Hospital without the prior approval of Health Information Management and Administration, and in compliance with Hospital policies and procedures.

(b) Copies of Patient information can be requested from Health Information Management and will be provided according to Hospital policy.

59. Out-Patient Records

(a) The health record of an out-Patient who visits the Hospital solely for diagnostic procedure(s) need only include the order(s) for the procedure(s), any consent to the procedure(s), the authorized consent for the procedure(s), and a record of the procedure(s).

(b) The health records of an out-Patient, other than an out-Patient referred above, shall include:

(i) the name of the attending Medical/Professional Staff member of the out-Patient at each visit;

(ii) a history of the out-Patient visit;

(iii) records of all Medical/Professional Staff examinations carried out on the out-Patient in the Hospital;

(iv) all diagnostic imaging records of the out-Patient and reports made by a Physician, Dentist, Midwife, or Registered Nurse in the Extended Class of the results of the radiological examination;

(v) all recordings of an out-Patient's examinations or tests where the recordings constitute the only hard copy evidence of the examinations or test, the results

of the examinations or tests, and reports made by a Physician of the results of the examinations or tests;

(vi) all orders for treatment or investigation for the out-Patient in the Hospital;

(vii) all authorized consent to treatment of the out-Patient;

(viii) all opinions required to be noted under subsection 25(5) of the *Health Care Consent Act, 1996* for the out-Patient;

(ix) records of all treatment carried out by Medical/Professional Staff on the out-Patient;

(x) all reports of investigative procedures carried out on the out-Patient;

(xi) all diagnoses for the out-Patient; and

(xii) a death certificate if the out-Patient dies in the Hospital.

60. Pre-admission Documentation

(a) Where documentation on a pre-admission history, physical examination, and diagnosis is dictated into the health record or a hard copy (paper) is provided for the record, the MRP/D/M shall be responsible to date, and authenticate the note in the health record within 24 hours after admission to indicate that the pre-admission documentation accurately reflects the Patient's current clinical condition. If there is any change, it should be noted in the health record.

(b) Where a Medical/Professional Staff member dictates a pre-admission history and physical examination for elective surgical Patients, they must do so at least 72 hours and not more than 30 days before surgery. Exceptions are those for Patients booked for a Monday or a Tuesday (where Monday is a statutory holiday) and the history and physical examinations are to be dictated before 0800 hours on the previous Friday. Failure to do so may result in the cancellation of the elective procedure. If the Patient's condition has changed from the time of original dictation to the procedure, an updated note must be provided. The Medical/Professional Staff member shall be responsible to date and authenticate the note in the health record within 24 hours after admission to indicate that the pre-admission documentation accurately reflects the Patient's current clinical condition.

61. Admission History and Physical Examination

(a) Where a patient is admitted for treatment by a Physician, the MRP shall, within 24 hours of the admission:

(i) take a medical history of the Patient;

(ii) conduct a physical examination of the Patient;

(iii) provide a diagnosis of the Patient's medical condition; and

(iv) record, date, and authenticate the history and a report of the findings of the physical examination and the diagnosis of the Patient.

(b) Where a Patient is admitted for treatment by a Dentist, the MRD shall, within 24 hours of the admission:

(i) take a dental history of the Patient that relates to the reason for the treatment;

(ii) conduct a dental and oral examination of the Patient;

(iii) provide a diagnosis of the Patient's dental condition; and

(iv) prepare, date, and authenticate the history, and a report of the findings of the examination, and the diagnosis and a statement of the proposed course of dental treatment for the Patient.

(c) Where a Patient is admitted to the Hospital for dental surgery, the attending Dentist shall ensure that subsection (b) above has been completed before commencing surgery.

(d) Where a Patient is admitted for treatment by a Midwife, the MRM shall, within 24 hours of admission:

(i) take a history of the Patient;

(ii) conduct a physical examination of the Patient;

(iii) provide a diagnosis or assessment of the Patient's condition; and

(iv) record, date, and authenticate the history and a report of the findings of the physical examination and the assessment of the Patient.

62. Surgery

(a) No surgeon shall perform a surgical operation on a Patient unless the surgeon:

(i) performs a physical examination of the Patient sufficient to enable the surgeon to make a diagnosis;

(ii) authenticates and enters or causes to be entered on the health record, a statement of the findings on the physical examination and the diagnosis;

(iii) has obtained informed consent as set out in the *Health Care Consent Act, 1996*; and

(iv) has documented on the health record that an informed consent has been obtained consistent with Hospital policy on informed consent.

(b) Every surgeon who performs a surgical operation in the Hospital shall prepare or cause to be prepared by a person qualified to do so, a written description of the operative procedure, as well as the findings and diagnosis made at the operation. The written description shall be authenticated by the surgeon performing the operation and the person making the description.

63. Progress Notes

(a) Progress notes shall be documented as the events occur and shall give a pertinent chronological report of the Patient's course. These shall be sufficient to describe changes in the Patient's condition, the outcome of the treatment, and discharge planning. Not only is it important to note in the health record when the Patient develops problems, but also document when they are doing well, as this helps to define the course of their clinical recovery.

(b) For acute care Patients, documentation of progress will vary from several times to once daily.

(c) For Patients identified as Alternate Level of Care or Rehabilitation, progress notes will be documented for each Patient visit and at least every seven days. Changing clinical conditions may necessitate more frequent progress notes.

(d) Physicians, Dentists, Midwives, and Registered Nurses in the Extended Class shall accurately provide full descriptions of the diagnoses/diseases and procedures performed during the Patient's admission in order to ensure the validity of statistical data for planning, research, and funding purposes.

64. Consent

(a) All Professional Staff shall adhere to the Hospital's consent policy. Authorized consent to treatment shall be obtained for required in-Patient and out-Patient procedures. Corporate Manual Policy– #3-100 Consent to Treatment

(b) If refusal by a parent or a person having lawful custody appears to the MRP/D/M to be detrimental to the Patient, the Chief of Department, Chief of Staff, or the Chief Executive Officer shall be informed. An ethics consultation may be requested.

65. Orders for Treatment

(a) Every order for treatment or diagnostic procedure shall be dated and signed by the Medical/Professional Staff member giving the order at the time of the order.

(b) Telephone orders shall be authenticated on the first visit to the Hospital by the Medical/Professional Staff member who dictated the order or by one of their call group colleagues if appropriate.

(c) All medication orders shall include Patient name, date, time, medication name, dose, frequency, route, and signature of the prescribing Medical/Professional Staff member.

66. Transfer Summary

(a) When a Patient is transferred from one Program to another or from the Hospital to another health care facility, a detailed transfer note with adequate information to enable the next attending physician to assume care of the Patient must accompany the Patient. The attending Physician is responsible for ensuring the completion of the transfer note before the transfer.

(b) In-house Patient transfers from the ICU to any other clinical unit will also require transfer orders.

(c) All Patient transfers require medication reconciliation.

67. Discharges

(a) A discharge order and summary must be prepared and signed for all admitted Patients. An uncomplicated obstetrical and/or newborn stay of less than 48 hours does not require a discharge summary.

(b) Physicians, Dentists, and Midwives shall assign diagnoses using the following categories:

(i) most responsible for admission;

(ii) primary diagnosis;

(iii) secondary diagnoses; and

(iv) complications.

(c) Physicians, Dentists, and Midwives shall assign the principal procedure as the procedure considered to be the most significant during the Patient's stay at the Hospital.

(d) Discharge against professional advice requires an order to discharge the record and completion of a discharge summary, as outlined under "Discharge Against Professional Advice" section of these Rules and Regulations.

(e) Physicians, Dentists, and Midwives shall complete medication reconciliation at the time of discharge.

68. Repeat Visits

When a Patient returns to the Hospital, from time to time, for repeat visits for any treatment including a series of visits for the same injury or illness, a note indicating the reason for the return visit, the Patient's current clinical status, and a diagnosis shall be recorded in the health record.

69. Electronic Authentication

(a) Dictation may be electronically authenticated by virtue of a Medical/Professional Staff member using their unique dictation number. If the Health Information Management Department is not notified to revise the document within seven days, the dictation will be considered to be signed by the Medical/Professional Staff member. Medical/Professional Staff members must not share their unique dictation number with other Medical/Professional Staff members or with Residents or students.

(b) The authentication process applies to all dictation done through the central dictation system relating to in-Patients, emergency Patients, medical day care Patients, surgical day care Patients, and ambulatory care patients.

(c) Medical/Professional Staff members acknowledge the necessity for maintaining the confidentiality of their identification number, and accept full responsibility for the form and content of transcription following authentication.

70. Death Certificate

(a) When a Patient dies in the Hospital, the MRP or Physician providing on-call coverage shall, within six hours of the death notice, complete a legible Medical Certificate of Death – Form 16 in black or blue ink with all required fields completed including the interval between onset and death (if interval unknown enter as "unknown"). A copy of the Form 16 must be filed in the health record.

(b) Where a coroner is required to complete the Medical Certificate of Death, the MRP or Physician providing on-call coverage shall remain responsible for the completion of the Death Certificate.

(c) Where a coroner is required to complete a Medical Certificate of Death and the coroner does not provide the attending Physician with a copy of the Medical Certificate of Death, the attending Physician shall complete a report in Form 1 and cause a copy of the report to be filed in the health record.

71. Suspension of Admitting Privileges

The Board may, upon the recommendation of the Chief of Staff, suspend the admitting Privileges of any Physician, Dentist, Midwife, or Registered Nurse in the Extended Class, who, without reasonable justification, has failed to complete any health record(s) made available to them during the preceding calendar month(s) pursuant to Hospital policy.

72. Suspension Procedures

(a) Suspension for incomplete health records will be handled according to the Health Information Management policy. Corporate Manual Policy– #12-34 Health Record Completion

(b) Those Medical/Professional Staff members who are on vacation will be exempt from suspension, provided that they have notified the Health Information Management Department before leaving for their vacation.

(c) The Board may re-instate Privileges in extenuating circumstances without the completion of health records.

(d) Health records unavailable to Medical/Professional Staff members for completion will not be considered delinquent, and the completion date will be adjusted.

B CLINICAL RULES

73. Consultations

In the following circumstances, the MRP/D/M shall be advised to consult with one or more appropriate Medical/Professional Staff members regarding:

(a) a Patient who is recommended for an operation, but whose condition is such as to indicate that the Patient may be a poor operative risk;

(b) a Patient where there is a failure to progress as expected under treatment;

(c) a Patient where a serious problem of diagnosis or management exists; and

(d) all other cases in which the Department, Division, or Program requires that a consultation be requested.

74. Consultations for Pregnant Patients

No pelvic or abdominal operation shall be performed upon a pregnant woman without prior consultation with a Medical/Professional Staff member of the obstetrical/gynaecological staff and without the indication for such an operation being recorded in writing on the health record and signed by the attending Physician and the consultant. Any Patient who is pregnant and admitted for any diagnosis under a MRP who is not an obstetrician or Midwife, must be seen in consultation by an obstetrician including daily rounding as clinical conditions require.

75. Delegated Controlled Acts

(a) Only those medical acts designated by the CPSO may be delegated to non-physicians.

(b) Only those acts sanctioned as within their scope of practice by the receiving profession, may be delegated.

(c) The delegation of medical controlled acts to non-physicians must be approved by the Medical Advisory Committee.

76. Medical Responsibility During Transfer of Patients Between Hospitals

(a) Patients shall be transferred from the care of a physician or dentist at the sending hospital to the care of a physician or dentist at the receiving hospital.

(b) The sending physician or dentist must communicate directly with the receiving physician or dentist before transfer. Appropriate plans for care of the Patient en route should be developed. These arrangements shall be documented in the health record.

77. Medication and Drug Formulary System

(a) The Medical Advisory Committee shall ensure the preparation, updating, and maintenance of the Hospital formulary by the Medication and Therapeutics Committee and consider their recommendations for approval and implementation.

(b) Medications used shall be those approved as per the Corporate Manual Policy – #2-09 Drug Formulary System as recommended by the Medication and Therapeutics Committee.

(c) The Hospital staff shall acquaint themselves with and adhere to the rules regarding medication administration as stated in the Corporate Manual Policy – #2-09 Drug Formulary System, including the following, which shall be incorporated into policies:

(i) change/addition of a medication to the formulary;

(ii) non-formulary medications;

(iii) restricted/controlled medications;

(iv) investigational medications;

(v) medication orders, including standing orders and routines, dosage ranges, automatic substitution, and automatic stop orders;

(vi) self-medication/bedside medications;

(vii) adverse medication reactions; and

(viii) medication incidents.

78. Dangerous Patient

A Medical/Professional Staff member who knows or suspects that a person being admitted to the Hospital on their order is or may become dangerous to themselves or to other persons

shall follow hospital policies and procedures. See Corporate Manual Policy #2-119 Flagging Patients – Workplace Violence Prevention

79. Infectious Patient

A Medical/Professional Staff member who knows or suspects that their Patient is suffering from an infectious disease or condition shall forthwith notify the Hospital infection control practitioner and follow hospital policies and procedures. See Interdisciplinary Clinical Manual Policy #15-77 Routine Practices

80. New Procedures/Operations

(a) New procedures and operations not previously performed at the Hospital must be approved by the Medical Advisory Committee.

(b) All requests for new procedures/operations should be directed to and approved by the appropriate Chief of Department, Chief of Staff, and Credentials Committee before review by the Medical Advisory Committee.

(c) Requests for new procedures/operations will require proof of competency and:

(i) an impact analysis; and

(ii) a review of the benefits and risks to Patients.

81. Requests of Guests/Observers in Hospital

Requests for observership by non-medical/non-midwifery students and health professionals without Privileges at the Hospital should be made in writing to the appropriate Chief of Department and Chief of Staff. No permission will be granted for the above to touch or participate in the treatment of Patients at the Hospital.

82. Death

(a) The MRP or Physician providing on-call coverage is responsible for pronouncing death promptly. A registered nurse may pronounce death when the death is expected; that is, when, in the opinion of the health team, the Patient is irreversibly and irreparably terminally ill and there is no treatment to restore health.

(b) A registered nurse will not pronounce death when:

(i) death is unexpected; and

(ii) the coroner needs to be notified.

(c) Following the death of a Patient, the MRP or Physician providing on-call coverage will determine if:

(i) the coroner should be notified;

(ii) a post-mortem examination should be performed; and

(iii) there is Patient suitability or request for organ/tissue donation in compliance with the Trillium Gift of Life Guidelines.

(d) The MRP or Physician providing on call coverage is responsible for:

(i) completing and signing the Medical Certificate of Death (form 16-*Vital Statistics Act*) or if required, the Certificate of Death (Form 1-*Public Hospitals Act*) in coroner's cases;

(ii) notifying the coroner when appropriate;

(iii) obtaining consent for clinically indicated autopsies in non-coroner cases; consultation with the Pathologist is required, Interdisciplinary Clinical Manual – #3-65 Death Management -Coroner and Pathologist Guidelines;

(iv) following procedures of the Trillium Gift of Life Guidelines and the Hospital's policy in obtaining consent for the removal of all organs/tissues for donation Interdisciplinary Clinical Manual – #3-68 Organ and Tissue Donation; and

(v) notifying the next of kin or substitute decision maker.

(e) It is each Medical/Professional Staff member's responsibility to be knowledgeable of the provisions of the *Coroners Act*, particularly as it pertains to reporting of deaths. If there is any question about reporting of a death to the coroner's office, the Medical/Professional Staff member should consult with the coroner's office.

83. Notification of Coroner

Notice to the coroner of a death shall comply with the requirements of the *Coroners Act.* Section 10(1) of the *Coroners Act* states:

"10(1). Every person who has reason to believe that a deceased person died,

(a) as a result of:

(i) violence,

(ii) misadventure,

(iii) negligence,

(iv) misconduct, or

(v) malpractice

(b) by unfair means;

(c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable thereto;

(d) suddenly and unexpectedly;

(e) from disease or sickness for which they were not treated by a legally qualified medical practitioner;

(f) from any cause other than disease; or

(g) under such circumstances as may require investigation,

shall immediately notify a coroner or a police officer of the facts and circumstances relating to the death."

C QUESTIONS AND CONCERNS ABOUT THE RULES AND REGULATIONS

84. Questions or Concerns

Questions or concerns about the Rules and Regulations can be addressed to the Chief of Department, the M/PSA Executive and/or the Chief of Staff.