MEDICAL STAFF RULES – PART I
CONDUCT AND MEDICAL STAFF ORGANIZATION

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Medical Staff Rules
For
Interior Health Authority

Part I
Conduct and Medical Staff Organization

INDEX

PREAMBLE

The *Medical Staff Bylaws* for Interior Health Authority (the "Authority") set out the conditions under which members of the Medical Staff serve the facilities and programs operated by the Interior Health Authority, provide patient care, and offer medical, dental, midwifery and nurse practitioner care advice to the Board.

The *Medical Staff Bylaws* provide that the Board of Directors shall:

- appoint a Health Authority Medical Advisory Committee (the "HAMAC") and such additional Committees as the HAMAC may deem necessary to effectively discharge its assigned role and responsibilities;
- upon the recommendation of the HAMAC and the Medical Staff, establish Rules necessary for the proper conduct of the Medical Staff which are not in conflict with the Hospital Act and its Regulation, the Bylaws and policies of the Interior Health Board of Director (the "Board"), or the *Medical Staff Bylaws*; and
- upon the advice of the HAMAC, organize the Medical Staff into departments, divisions and sections as warranted by the professional resources of the Medical Staff.

This document presents Rules governing the conduct of the Medical Staff in facilities and programs operated by the Interior Health Authority including the details of the Medical Staff Organization and the day to day processes by which the members of the Medical Staff provide patient care, which are in keeping with the intent of the *Medical Staff Bylaws*.

For administrative purposes and ease of distribution, and to facilitate such revisions as may be recommended from time to time, the Terms of Reference for the HAMAC and supporting committee structure have, with the agreement of the HAMAC, been approved in a separate document – *Interior Health Authority Board Policy 9.3 – Medical Staff Rules Part II –Terms of Reference for the Health Authority Medical Advisory Committee*.

DEFINITIONS

Appointment – The process by which a physician, dentist, midwife or nurse practitioner becomes a member of the Medical Staff of the Interior Health Authority. Appointment does not constitute employment.

Attending Practitioner – See Most Responsible Practitioner

Board of Directors – The governing body of the Interior Health Authority

Chief Executive Officer (CEO) – The person engaged by the Interior Health Authority to provide leadership to the health authority and to carry out the day-to-day management of the facilities and programs operated by the health authority in accordance with the Bylaws, Rules and policies of the Interior Health Authority

Chief of Medical Staff - A member of the Active Medical Staff responsible for the assurance of the quality of medical care provided by members of the Medical Staff within a facility and for providing local medical input into operational decisions

Clinical Program Director - The member of the Medical Staff who, jointly with the Administrative Program Manager, directs the operation of and provides leadership to an interdisciplinary program team

Delegated Medical Act – A medical act that, with the agreement of the relevant medical department(s), has been transferred to another health care professional in the interest of good patient care and efficient use of health care resources.

Dentist – A member of the Medical Staff who is duly licensed by the College of Dental Surgeons of British Columbia and who is entitled to practice dentistry in British Columbia

Department – A major component of the Medical Staff composed of members with common clinical or specialty interest

Department Head – The member of the Medical Staff appointed by the Interior Health Authority and responsible to the Senior Medical Administrator (VP Medicine) or his/her delegate to be in charge of and responsible for the operation of a Medical Staff Department

Division – A component of a Department composed of members with a clearly defined sub-specialty interest

Division Head - The member of the Medical Staff appointed by and responsible to a Department Head to be in charge of and responsible for the operation of a Medical Staff Division

Executive Medical Director – The physician appointed by the Senior Medical Administrator (VP Medicine), responsible for the coordination and direction of the activities of the Medical Staff within a Region or Program

Facility – A health care facility as defined by the *Hospital Act* and its *Regulations* of British Columbia

Health Authority Medical Advisory Committee (HAMAC) – The advisory committee to the Interior Health Authority on medical, dental, midwifery and nurse practitioner practice matters, as described in Article 8 of the *Medical Staff Bylaws*

Local Medical Advisory Committee (LMAC) – The advisory committee established by the RMAC at individual sites within their operating area with written Terms of Reference that are in keeping with site needs and the roles and responsibilities delegated to the RMAC

Medical Care – For the purposes of this document, medical care includes the clinical services provided by physicians, dentists, midwives and nurse practitioners.

Medical Staff – The physicians, dentists, midwives and nurse practitioners who have been granted privileges by the Board of Directors to practice in the facilities and programs owned and operated by the Authority.

Medical Staff Association - The body of Medical Staff members in various facilities and programs of the Interior Health Authority whose professional interests are represented by their elected officials

Medical Staff Organization -The membership of the Medical Staff including every practitioner regularly practicing in the facilities and programs of the Interior Health Authority organized in accordance with the *Hospital Act Regulations*

Medical Staff Policy – Administrative guidelines/policies establishing standards for medical care of patients within the facilities and programs operated by the Interior Health Authority

Medical Staff Rules (or Rules) – The Rules approved by the Board of Directors governing the day-to-day management of the Medical Staff in the facilities and programs operated by the Interior Health Authority

Midwife – A member of the Medical Staff who is duly licensed by the College of Midwives of British Columbia and who is entitled to practice midwifery in British Columbia

Most Responsible Practitioner (MRP) - The practitioner who has accepted the overall responsibility for the management and coordination of care of the patient at any given time (also known as the Attending Practitioner)

Nurse Practitioner (NP) – A member of the Medical Staff who is duly licensed by the College of Registered Nurses of British Columbia, and who is entitled to practice nursing as a nurse practitioner in British Columbia.

Oral and Maxillofacial Surgeon – A dentist who holds a specialty certificate from the College of Dental Surgeons of British Columbia authorizing practice in oral and maxillofacial surgery.

Physician - A member of the Medical Staff who is duly licensed by the College of Physicians and Surgeons of British Columbia and who is entitled to practice medicine in British Columbia

Practitioner – A physician, dentist, midwife or nurse practitioner who is a member of (appointed to) the Medical Staff of the Interior Health Authority

Primary Department – The Department to which a member of the Medical Staff is assigned according to his/her training, and where the member delivers the majority of care to patients

Privileges – A permit to practice medicine, dentistry, midwifery, nursing as a nurse practitioner, or as a member of the other regulated health professions in the facilities and programs operated by the Interior Health Authority and granted by the Interior Health Authority to a member of the Medical Staff, as set forth in the Hospital Act and its Regulations. Privileges describe and define the scope and limits of each practitioner's permit to practice in the facilities and programs of the Interior Health Authority

Program – An ongoing care delivery system under the jurisdiction of the Interior Health Authority for coordinating a specified type of patient care

Region (or Health Service Area) – A defined health service delivery area within the health authority

Regional Medical Advisory Committee (RMAC) – The advisory committee established at each of the Interior Health Authority's four Regions (Health Service Areas) which has delegated responsibilities and Terms of Reference approved by the HAMAC

Regulations – The Regulations made under the authority of the *Hospital Act*

Reserved Medical Act – A medical act or function which, under the scope of practice as currently approved by the Minister of Health, may be performed only by a member of the Medical Staff

Section – A component of a Division composed of members with clearly defined sub-specialty interests

Section Head **-** The member of the Medical Staff appointed by and responsible to the Division Head to be in charge of and responsible for the operation of a Medical Staff Section

Senior Medical Administrator (VP Medicine) – The physician, appointed by the CEO, responsible for the coordination and direction of the activities of the Medical Staff

Specialist – A physician with Fellowship or Certificate or status with the Royal College of Physicians and Surgeons of Canada or equivalent or relevant clinical experience to practice as a specialist by the College of Physicians and Surgeons of British Columbia

Temporary Privileges – A permit to practice in the facilities and programs operated by the Interior Health Authority that is granted to a member of the Medical Staff for a specified period of time in order that he/she may provide a specific service

Vice President (VP) – The person engaged by the Interior Health Authority to provide leadership and to carry out the day to day management of the facilities and programs operated by the health authority in accordance with the Bylaws, Rules and policies of the Interior Health Authority

SECTION 1 - AUTHORITY TO MAKE AND AMEND RULES

1.1 As provided for in Article 12 of the *Medical Staff Bylaws*, the *Medical Staff Rules* are established by the Board of Directors upon the recommendation of the HAMAC and the Medical Staff.

1.2 All recommendations for amendment of the *Medical Staff Rules* must be reviewed by the HAMAC who will provide advice to the Board of Directors.

1.3 *Medical Staff Rules* and amendments thereto are effective when approved by the Board of Directors.

1.4 A copy of the *Medical Staff Rules* shall be sent to all members of the Medical Staff, after which all members shall be deemed to be familiar with them.

1.5 A copy of the *Medical Staff Rules* signed by the Chair of the Interior Health Authority Board of Directors and the Chair of the HAMAC may be given in evidence in any proceeding in the Interior Health Authority without any further proof of authenticity.

SECTION 2 - MEDICAL STAFF MEMBERSHIP AND PRIVILEGES

2.1 Terms and criteria for appointment to the Medical Staff, as well as procedures for application and review, are detailed in Articles 3 and 4 of the *Medical Staff Bylaws*.

2.2 Appointment to the Medical Staff shall be Health Authority wide. Within that appointment, the privileges granted to each member of the Medical Staff by the Board of Directors shall describe and define the scope and limits of each practitioner's permit to practice in the facilities and programs of the Interior Health Authority. Any active staff member at a facility or program may be given active staff privileges at another facility or program by the Board of Directors with appropriate review and recommendation of the respective Department Head, Chief of Medical Staff, Executive Medical Director and RMAC.

2.3 The application for appointment of all specialists and all General Practitioners providing specialist type services shall require the completion of an impact analysis in accordance with Article 3.1.5 of the *Medical Staff Bylaws*.

2.4 Locum Tenens

2.4.1 Appointments for locum tenens are governed by Article 6.6 in the *Medical Staff Bylaws*. The granting of a locum tenens appointment provides no preferential access to appointment to any other category of the Medical Staff at some later time.

2.4.2 The Medical Staff member who will be replaced by a locum tenens and the relevant Department Head are responsible for ensuring that the locum tenens is suitably qualified. They shall familiarize the locum tenens with facility and program policies and procedures necessary for the medical care of patients.

2.5 Procedural Privileges

2.5.1 Procedural privileges are granted at the time of initial appointment to Medical Staff membership based on service needs of the Interior Health Authority and the qualifications of the Practitioner. As part of the annual review of all privileges, maintenance of procedural privileges will be determined by proven competence and ongoing expertise as well as program requirements.

2.5.2 Application for additional procedural privileges shall be through the standard credentialing process in consultation with appropriate Department Heads and Program Directors who shall advise on the appropriate training of the applicant and demonstrated service need within the program.

2.6 In-depth Performance Evaluations

2.6.1 In-depth review is the periodic, or ongoing, evaluation of a Medical Staff member's practice and performance and occurs in addition to, or in conjunction with, the member's annual review. The intent of in-depth review is quality improvement and the process is designed to be educational and potentially corrective. In-depth review should be performed in accordance with disclosure safeguards found in Section 51of the *Evidence Act*. The results and recommendations of the in-depth review will be sent to the Board of Directors through the HAMAC via its credentialing process.

2.6.2 All members of the Medical Staff are subject to an in-depth review prior to their appointment from the Provisional Medical Staff to the Active Medical Staff and every fifth year thereafter. The process will be coordinated and delegated as appropriate by the Executive Medical Director and may include review of any or all of, but not be limited to, the following:

- inpatient and outpatient clinical documentation for quality, accuracy and timeliness
- complications, morbidity and mortality review
- incident reports and complaints
- continuing medical education including updates specific to departmental and/or program requirements
- patient satisfaction data
- procedural privilege evaluation including frequency of procedures done
- direct observation of procedural and assessment skills
- communication with medical colleagues and other members of the health care team and Interior Health Authority staff with whom the member works
- utilization data

2.6.3 The Department Head or the Chief of Medical Staff will discuss the results and recommendations of the in-depth review with the Medical Staff member before the final report is sent through the LMAC to the RMAC.

2.7 Other Regulated Health Care Professionals

2.7.1 All modes of care provided for patients within the facilities and programs of the Interior Health Authority shall be provided only by employees of the Interior Health Authority or by professionals with a permit to practice granted by the Board of Directors. Health Care Professionals other than those prescribed in the *Hospital Act Regulation* may apply for membership on the Other Regulated Health Care Professional Staff.

2.7.2 The Senior Medical Administrator (VP Medicine) shall be responsible for the overall administration of the Other Regulated Health Care Professional Staff. The processes of initial appointment, annual and in-depth reviews, procedural privileges, utilization and quality assurance may be delegated.

2.7.3 Process for Granting Privileges for Other Regulated Health Care Professionals

The approval process for granting privileges for Other Regulated Health Care Professionals is the same as for applicants to the Medical Staff, with the following amendments:

2.7.3.1 Initial Requirements

(a) There is a demonstrated patient need, confirmed by the Senior Medical Administrator (VP Medicine), or delegate, and the senior administrator.
(b) The applicant is a member in good standing of the appropriate College of one of the professions included under the Health Professions Act, as listed below, and is not already an employee of Interior Health.

- Chiropractic
- Dental Hygiene
- Dental Technology
- Denturism
- Massage Therapy
- Naturopathic Medicine
- Opticianry
- Optometry
- Podiatric Medicine
- Psychology
- Traditional Chinese Medicine and Acupuncture

2.7.3.2 Process for Approval

(a) Approval of a permit to practice may be given for a full year, but patients may only be seen at the request of the Most Responsible Practitioner (MRP) or Consulting Specialist. There must be a written order in the chart requesting the particular health professional to see the patient and it must include the length of time the service is to be provided to the patient.
(b) Clinics may be permitted if the Facility Administrator and the Executive Medical Director, or designate, support the request. An Impact Analysis must be done prior to the application being brought forward.

(c) Requests for approval for one day or less will be considered on an exception basis only.

2.7.3.3 Credentialing Process

Applicant must provide the following:

(a) Proof of registration or licensure with a professional College.
(b) A certificate of good standing from the appropriate College.
(c) A completed Impact Analysis if the request involves provision of a clinic.
(d) Approval from the Most Responsible Practitioner (MRP), documented on the patient record, if request is from a patient.
(e) Proof of membership in an organization with professional liability insurance in a category appropriate to the practice of the applicant, subject to approval by the Board of Directors.
(f) Three references as follows:

- If the applicant has worked in a healthcare facility, one reference from either the Chief of Staff or Senior Medical Administrator of the facility; or
- If the applicant has not worked in such a facility, one reference from a licensed physician; or
- If the applicant is a new graduate, one reference from the training program director; and
- Two references from other Health Professionals practicing in the same profession

SECTION 3 - POSTGRADUATE TRAINING PROGRAMS

3.1 Resident Staff

3.1.1 Appointments

All appointments to Resident Staff shall be made through the office of Medical Postgraduate Education in conjunction with the Faculty of Medicine at the University of British Columbia (UBC) and licensed by the College of Physicians & Surgeons of British Columbia.

3.1.2 Resident Staff

Resident Staff may attend patients under the supervision of a member of the Active or Provisional Medical Staff of the department responsible for supervision of their work in the hospital. They may carry out such duties as are assigned to them by the Medical Staff member to whom they have been assigned. (Further details of Resident Staff roles and responsibilities are available through the office of Medical Postgraduate Education at the University of British Columbia (UBC)).

3.2 Clinical Fellows

3.2.1 Appointments

Clinical Fellows are physicians who have applied to and been accepted by the Interior Health Authority for further training in a clinical discipline. They must have adequate medical liability insurance, be licensed by the College of Physicians & Surgeons of British Columbia and be registered with the Faculty of Medicine at the University of British Columbia. Clinical Fellows shall be accepted only if supported by the Department Head concerned and recommended by the Medical Staff Resource Planning and Credentials Committee, the HAMAC and approved by the Board of Directors.

3.2.2 Clinical Fellows

Clinical Fellows may attend patients under the supervision of a member of the Active or Provisional Medical Staff of the department responsible for supervision of their work in the hospital. They may carry out such duties as are assigned to them by the Head of the Department or delegate to whom they have been assigned. They may not admit patients. They may not vote at Medical Dtaff or Department meetings.

3.3 Clinical Trainees

3.3.1 Appointments

Clinical Trainees are those physicians, dentists, midwives or nurse practitioner who have applied to and been accepted by the Interior Health Authority for further clinical training. They must have adequate liability insurance and be licensed by the College of Physicians and Surgeons of British Columbia, the College of Dentistry of British Columbia, the College of Midwives of British Columbia, or the College of Registered Nurses of British Columbia. Clinical Trainees shall be accepted only if supported by the Department Head concerned and recommended by the Medical Staff Resource Planning and Credentials Committee, the HAMAC and approved by the Board of Directors.

3.3.2 Clinical Traineeships

The purpose of a Clinical Traineeship is to provide a licensed physician, dentist, midwife or nurse practitioner an opportunity to maintain or enhance their clinical skills. Clinical Trainees may attend patients under the supervision of a member of the Active or Provisional Medical Staff of the department responsible for supervision of their work in the hospital. They may carry out such duties as are assigned to them by the Department Head or delegate to whom they have been assigned. They may not admit patients. They may not vote at Medical Staff or Department meetings.

3.4 Students

3.4.1 Medical Students

All Medical Students working within a hospital, program or department must either be registered through the Faculty of Medicine at the University of British Columbia or be attending a WHO/FAIMER-recognized medical school and have a valid educational license from the College of Physician and Surgeons of British Columbia. Medical students may attend patients under the direct supervision of a member of the Active or Provisional Medical Staff, Resident staff or a Clinical Fellow in the department responsible for their training program. Orders written by medical students must have been discussed with the supervisor prior to being written and must be countersigned at the earliest opportunity, within 24 hours. Medical students shall not sign certificates of death. Medical Students shall not discharge patients without appropriate review by a qualified physician. Although not members of the Medical Staff, Medical students must abide by the policies and guidelines of Interior Health.

3.4.2 Midwifery, Nurse Practitioner and Dental Students

All Midwifery, Nurse Practitioner and Dental Students working within a hospital, program or department must either be registered through the University of British Columbia or be attending a school with which the Interior Health Authority has an affiliation agreement. The student must have a valid educational license from his/her professional College in British Columbia. Students may attend patients under the direct supervision of a member of the Active or Provisional Medical Staff, Resident staff or a Clinical Fellow in the department responsible for their training program. Orders written by students must have been discussed with the supervisor prior to being written and must be countersigned at the earliest opportunity, within 24 hours. Students shall not sign certificates of death. Students shall not discharge patients without appropriate review by a qualified member of the Medical Staff. Although not members of the Medical Staff, Students must abide by the policies and guidelines of Interior Health.

3.5 Elective Clinical Rotations

Medical Students, Residents and Clinical Fellows from the University of British Columbia (UBC) and from medical schools outside of British Columbia may be authorized by the Executive Medical Director to do elective clinical rotations at facilities and programs of the Interior Health Authority. All electives must be approved and registered through the Faculty of Medicine at the University of British Columbia and be licensed by the College of Physicians and Surgeons of British Columbia. The scope of practice and requirements for supervision shall be the same as the respective articles in this Section.

SECTION 4 - RESPONSIBILITY FOR THE PROVISION OF MEDICAL CARE IN THE FACILITIES AND PROGRAMS OF THE INTERIOR HEALTH AUTHORITY

4.1 Each member of the Medical Staff has the duty to comply with Article 5 of the *Medical Staff Bylaws* including the responsibility to ensure that any patient they have admitted to hospital is continuously under appropriate and available Medical Staff care. Details of coverage will be determined by departments, divisions and sections including availability to be on-site in a reasonable response time as determined by the urgency of patient need.

4.2 When, in the opinion of the Most Responsible Practitioner (MRP), clinical resources are not available for the appropriate and safe care of the patient, the practitioner shall initiate a process to transfer the patient to a more suitable facility. The practitioner shall be responsible to identify the patient who requires transfer, the resources needed and provide relevant medical information in keeping with clinical policies and procedures where they apply, (e.g. Policy AH0300 "No Refusal", and BC Patient Transfer Network). The transfer of the patient to a facility with adequate resources shall be the responsibility of hospital management and its staff.

4.3 The Department, Division or Section Head, with the agreement of their members, shall ensure that there is a reasonable on-call schedule. All members of the Medical Staff with admitting privileges shall participate in departmental, divisional or sectional on-call rosters at a designated facility(s). Participation in on-call rosters can be adjusted in special circumstances as defined by the Department, Division or Section Head with the agreement of their members. On-call requirements, terms and conditions may also be governed through contractual arrangements between the Interior Health Authority and individual members of the Medical Staff.

4.4 When circumstances do not allow on-call coverage that is consistent with safe patient care, the Senior Medical Administrator (VP Medicine), Executive Medical Director or Chief of Medical Staff shall ask the relevant Department, Division or Section Head to make alternative arrangements.

4.5 Temporary changes in the availability of regional/facility resources may alter the requirement to provide emergency on-call coverage at a department, division or section level. In planning for such changes, the relevant Department, Division or Section Head, the affected members, and the relevant Program Directors shall meet to determine an appropriate level of on-call emergency coverage reflecting the altered level of resources provided.

4.6 Members of the Medical Staff when not available to provide care to their patients shall indicate the name(s) of the practitioner(s) assuming responsibility for each patient's care in accordance with the Most Responsible Practitioner (MRP) policy.

4.7 Consistent with quality monitoring standards and risk management practices, patient care services and therapies within facilities operated by the Interior Health Authority will be provided solely by Interior Health Authority employees, Medical Staff granted privileges by the Board of Directors, or by Allied Health Professionals approved by the Board of Directors.

4.8 When more than one practitioner is involved in the care of the patient, a Most Responsible Practitioner (MRP) must be identified in accordance with Medical Staff Policy.

4.9 The transfer of Most Responsible Practitioner (MRP) status (other than "on-call") from one practitioner to another shall be duly recorded on the order sheet. It is the duty of the Most Responsible Practitioner (MRP) to contact and obtain agreement from the practitioner to whom he/she wishes to transfer care. When the Most Responsible Practitioner (MRP) is part of an in-house service (e.g. Hospitalist, Intensivist) transfer of Most Responsible Practitioner (MRP) status shall be automatically accepted by the physician on the following shift. The initial Most Responsible Practitioner (MRP) for a patient on that service shall remain the nominal Most Responsible Practitioner (MRP) for the patient until the patient is discharged from the facility or until the patient is transferred off the service.

4.10 If a practitioner wishes to withdraw from involvement in a patient's care when services are still required, the member shall arrange for another practitioner with appropriate qualifications to assume responsibility for the care of the patient and then inform the patient. If the practitioner cannot find another practitioner who is willing to assume care, the original Medical Staff member will continue to provide care to the patient. The practitioner who is seeking to withdraw service may discuss options with the appropriate Department or Division Head or Chief of Medical Staff to determine what other options may be available.

4.11 A patient has the right to request a change of practitioner. That practitioner shall cooperate in transferring responsibility for care of that patient to another practitioner with appropriate privileges who is acceptable to the patient. If an acceptable practitioner cannot be found, the appropriate Department or Division Head shall assist the patient in finding another practitioner who will agree to continue to provide care to the patient. If a willing practitioner cannot be found, the Department or Division Head will discuss options with the patient.

4.12 Disciplinary procedures for dealing with inadequacy of medical care quality and non compliance with *Medical Staff Bylaws*, Rules and policies are established by the HAMAC and are set-out in SECTION 17 – Discipline and Appeal.

SECTION 5 - ADMISSION, TRANSFER AND DISCHARGE OF PATIENTS

5.1 Admission and Transfer of Patients

5.1.1 Every patient shall be attended by a member of the Medical Staff who has admitting privileges and who has primary responsibility for the care of the patient. This practitioner shall be identified as the Most Responsible Practitioner (MRP).

5.1.1.1 Patients admitted for Dental Surgery shall be admitted under a member of the Medical Staff with admitting privileges who shall be the Most Responsible Practitioner (MRP).

5.1.2 Patients admitted to a facility when there has been no predetermined Most Responsible Practitioner (MRP), shall be assigned to a consenting available member of the Medical Staff with the appropriate skills, training and privileges to meet the patient's health care needs in accordance with local Most Responsible Practitioner (MRP) policy.

5.1.3 A medical history and complete physical examination is required for all patients receiving inpatient care at the time that the patient is admitted. The admission documentation should include:

- presenting problem
- allergies/sensitivities
- medications
- significant past medical, social and family history
- review of systems noting deviations from normal
- physical examination
- results of pertinent diagnostic investigations
- active problem list
- management plan with an estimated length of stay
- admitting diagnoses and/or differential diagnoses

5.1.3.1 When a patient requires admission in emergency circumstances, the physician who initially assesses and determines that the patient requires admission is responsible for documenting clinical findings, the diagnosis and treatment plan. The Most Responsible Practitioner (MRP) must ensure full documentation for each emergency patient within 24 hours of admission.

5.1.4 The Most Responsible Practitioner (MRP) must review the admission orders and where appropriate add additional history regarding the present illness, an updated problem list, a revised management plan including levels of intervention as per Interior Health Authority policy and a discharge plan within a timeframe set by Medical Staff Policy.

5.1.5 The admitting practitioner shall note special precautions regarding the care of the patient (e.g. infectious disease, emotional disturbance, elder alert, chemical dependency, potential suicide, history of violence, history of seizures, etc.) on the order sheet in the patient's health record at the time of admission or booking.

5.1.6 When a patient is to be transferred to another hospital or facility for medical reasons, the Most Responsible Practitioner (MRP) shall ensure that there is an appropriately qualified practitioner on staff at the receiving site who is fully informed about the patient's condition and who is prepared to assume responsibility for the patient's care. The Most Responsible Practitioner (MRP) shall identify relevant documentation from the patient's clinical record to be sent to the receiving hospital according to the provisions of the *Freedom of Information and Protection of Privacy Act.*

5.1.7 In those instances where a patient is transferred to another facility for administrative rather than medical reasons (e.g. lack of beds), the Most Responsible Practitioner (MRP) may choose to be relieved of the responsibility for ongoing care of that patient after transfer and hospital employees shall ensure that the move is completed in accordance with established policy and procedure.

5.1.8 A documented history for each Long Term Care patient should be received prior to the patient's admission to a Long Term Care unit or facility.

5.1.9 When a patient is readmitted to an acute care facility within 30 days for the same reason, an admission note may be completed in lieu of an admission history and physical.

5.2 Discharge of Patients

5.2.1 Patients shall be discharged only on the written order of the Most Responsible Practitioner (MRP) or delegate or the appropriate Department Head or Chief of Medical Staff. Whenever possible the Most Responsible Practitioner (MRP) will provide twenty-four hours' notice of anticipated discharge.

5.2.2 At the time of discharge, the Most Responsible Practitioner (MRP) or delegate shall sign the discharge order and, if possible, complete the discharge summary at the time of discharge.

5.2.3 A discharge summary is required for all patients with a length of stay longer than 2 days and for all patients transferred to another facility.

5.2.4 A discharge summary shall include:

- the discharge diagnosis
- other relevant diagnoses and co-morbidities
- procedures performed
- unexpected occurrences
- a summary of the patient's course in hospital and condition on discharge
- the disposition of the patient
- a list of medications including dosage and frequency
- instructions given to the patient and family

5.3 Completion of Health Records

5.3.1 Health records containing all relevant documents should be completed and validated by all involved practitioners within 14 days of the documents becoming available.

5.3.2 The surgical record of operation must be completed within 24 hours of the procedure.

5.3.3 If the practitioner is unable to complete and validate the health record because all relevant documents and reports are not available or completed the Health Information Management Services is to be notified by the practitioner.

5.3.4 Within 7 days prior to leaving on holidays, the practitioner shall complete all outstanding patient records (Section 5.3.1). Practitioners who have notified Medical Administration in advance of their absence shall not lose privileges for incomplete records identified during their absence. Outstanding records shall be completed within 14 days after the practitioner's return.

5.3.5 Locum tenens practitioners are responsible for the completion of the health records of patients they have been caring for. Records left incomplete shall be completed by the Medical Staff member replaced by the locum tenens. Failure of a locum tenens to complete clinical records may result in a review of that locum's privileges by the Department Head.

5.3.6 Practitioners leaving practice (e.g. retirement, relocation) must complete all patient records as far as availability of documents allows.

5.3.7 Written notification of failure to complete records shall be provided to the responsible practitioner by the Health Information Management Services. Within 7 days of issuance of this notice, the practitioner shall complete the identified records. Failure to do so may result in the suspension of all privileges except for the ongoing care of patients already in hospital until the records are completed.

5.3.8 Repeated failure to comply with the above regulations incurring an automatic suspension on 3 occasions during any 6 month period may result in a suspension of up to 30 days of all privileges following a review by the LMAC.

SECTION 6 - ORDERS FOR MEDICAL CARE AND PROGRESS NOTES

6.1 Orders

6.1.1 All orders for medical treatment shall be legibly written and signed by a practitioner with appropriate Medical Staff privileges. An order for medical care may be dictated over the telephone to a registered nurse, licensed practical nurse or registered psychiatric nurse. An order dictated over the telephone shall be written over the name of the ordering practitioner and be signed by the person to whom they are dictated. Such orders shall be counter-signed by the ordering practitioner as soon as possible – (as per CMPA recommendation). Orders on an Interior Health Authority physician order form may be faxed if signed by a member of the Medical Staff or a duly authorized nurse practitioner.

6.1.2 Telephone orders pertaining to other professional disciplines, e.g. occupational therapy, physical therapy, respiratory therapy, dietary, pharmacy, etc., may be given by the medical practitioner to a member of that discipline who shall write and sign the orders on the Physicians Order Sheet over the name of the ordering practitioner. Such orders shall be counter-signed by the ordering practitioner as soon as possible.

6.1.3 In an emergency a practitioner may give verbal orders for treatment to a registered nurse, to a respiratory therapist, to a perfusionist or to a pharmacist who shall transcribe the order onto the chart over the practitioner's name per the writer's name. Such orders shall be counter-signed by the ordering practitioner as soon as possible.

6.1.4 Practitioners prescribing medication shall comply with the *Narcotic Control Act* and other legislation pertaining to the use of drugs.

6.1.5 No drug, whether supplied by the hospital or not, may be administered to a patient without an order from a practitioner of the Medical Staff.

6.1.6 Where the HAMAC has approved standards, policies or guidelines for the use of a drug, such drugs will be supplied by the Director of Pharmacy in accordance with such directions. Practitioners who knowingly order medication in a manner that deviates from established standards, policies or guidelines shall accept full responsibility.

6.1.7 All medications ordered by a practitioner which are not listed in the hospital formulary shall be reviewed by the hospital pharmacy in accordance with Interior Health Authority policy.

6.1.8 Investigational drugs which are requested in an urgent situation may be used only with the approval of the Executive Medical Director, the Chief of Medical Staff, or the Pharmacy Director and on the order of the Most Responsible Practitioner (MRP).

6.1.9 Preprinted orders may be used by a medical department or division following approval by the Department or Division Head through their appropriate LMAC or RMAC which will review the preprinted orders annually. The practitioner is responsible for individualizing and signing the preprinted orders.

6.2 Progress Notes

6.2.1 Progress notes for acute care patients shall be sufficient to describe changes in the patient's condition, reasons for change of treatment, and outcome of treatment and shall be written as frequently as the patient's condition warrants but not less frequently than every day by the Most Responsible Practitioner (MRP). (Some long stay patients in rehabilitation and mental health units may require progress notes less frequently.)

6.2.2 The prenatal record is considered to be an integral part of the patient record. Documentation must be in accordance with the guidelines developed by the British Columbia Reproductive Care Program.

SECTION 7 – BOOKED TREATMENTS AND PROCEDURES

7.1 Booking and Pre-Treatment/Procedure Documentation Requirements

7.1.1 This section refers to all medical, surgical and interventional procedures or treatments that are required to be booked. Requirements for documentation and process shall be fully documented in the Medical Staff Policy Manual.

7.1.2 If booked treatments and procedures are cancelled for administrative reasons, hospital staff shall be responsible for rebooking the procedures in consultation with the practitioner and for notification of the patient and the practitioner.

7.2 Consent Requirements

7.2.1 No elective treatment(s) or procedure(s) shall be performed without the consent of the patient, the substitute decision-maker or the temporary substitute decision-maker as defined in legislation.

7.2.2 In an urgent or emergency situation, a reasonable effort shall be made to obtain consent from the patient, a substitute or temporary substitute decision maker. If this is unsuccessful, it is recommended that the practitioner consult with a second practitioner and obtain a concurring opinion for the recommended treatment(s) or procedure(s). The Most Responsible Practitioner (MRP) shall document on the patient record why consent could not be obtained and why the patient's condition represented an urgent or emergency situation.

7.2.3 For any individual not involved in direct care of the patient, patient consent is always required before observation of any treatment(s) or procedure(s) is allowed. All Medical Staff shall comply with any applicable policies pertaining to visitors to the operating room when requesting permission for visiting consultants, physicians, students etc. in the operating room.

7.3 Requirements for Surgical Procedures in Operating Rooms

7.3.1 The surgeon shall be the Most Responsible Practitioner (MRP) for peri-operative management of the patient and for the performance of the surgical procedure.

7.3.2 All major surgery will be performed with the assistance of a second physician or a trained assistant.

7.3.3 The supervisor of the operating room has the authority to cancel any operation if there is an inappropriate delay. The supervisor shall reschedule the operation with the main considerations being the patient's interests and the optimum use of the operating room suite. The report of any such delay shall be provided to the Operating Room Management Committee.

The surgeon must record the pre-operative diagnosis in ink on the operation form. The operation form must be completed with the post-operative diagnosis and the procedures performed before the patient leaves the operating room.

7.3.4 An anesthetic record must be completed prior to the patient leaving the operating room/post anesthetic recovery room. The post procedure note detailing unusual circumstances shall be documented on the chart before the patient returns to the ward. A report must be completed for incidents of clinical significance which may affect future patient care with copies made available to all practitioners providing ongoing care to that patient. The practitioner generating this report is to identify the specific practitioners who require copies of the report.

7.3.5 Before leaving the operating room, the surgeon shall ensure that the pathology requisition for examination of tissues or other material has been completed. All tissues or materials must be sent to the Pathology Department with the exception of those listed in the Medical Staff Policy.

7.3.6 All surgical operations performed shall be fully described in the "Report of Operation" by the surgeon within twenty-four hours.

7.3.7 All patient deaths that occur in the operating room/post anesthetic recovery room must be reported to the Coroner at the time of death in accordance with the Coroners Act. All such cases shall be referred for QA/QI review.

7.4 Requirements for Treatments/Procedures Performed Outside of Operating Rooms

7.4.1 On completion of treatment(s) or procedure(s) performed outside of an operating room, the practitioner shall document a progress note on the patient chart, describing the treatment(s) or procedure(s), the outcome and any unusual circumstances, before the patient returns to the ward. A report must be completed for all incidents of clinical significance which may affect future patient care with copies made available to all practitioners providing ongoing care to that patient. The practitioner generating this report is to identify the specific practitioners who require copies of the report.

SECTION 8 - CONSULTATIONS

8.1 Consultation is defined as the medical opinion of another member of the Medical Staff.

8.2 Consultation shall be initiated by the Most Responsible Practitioner (MRP), another practitioner or duly authorized nurse practitioner involved in the care of the patient. Communication shall always be from practitioner to practitioner. A written request for a consultation should state the purpose and nature of the consultation.

8.3 The Consultant shall examine the patient and the health record, record the findings, opinions and recommendations in the patient record and communicate with the Most Responsible Practitioner (MRP). Consultations should be completed as soon as possible in accordance with the clinical condition of the patient and within 48 hours in all cases. If the consultation cannot be completed within 48 hours, the consultant must notify the referring practitioner.

8.4 When a practitioner other than the Most Responsible Practitioner (MRP) initiates a request for consultation, that practitioner shall notify the Most Responsible Practitioner (MRP) of the request.

8.5 A Department or Division Head may request or require a practitioner with privileges in his/her department or division to obtain a consult when, in the opinion of the Department or Division Head:

- the diagnosis of the patient is in doubt after reasonable investigation; or
- the patient does not appear to be responding to the prescribed treatment; or
- the patient's condition is serious enough to be considered life threatening; or
- there are other circumstances which, in the opinion of the Department or Division Head, require consultation.

8.6 The Senior Medical Administrator (VP Medicine), Executive Medical Director or Chief of Medical Staff may direct a Department or Division Head to obtain a consultation as outlined in 8.5 (a), (b) or (c).

8.7 Consultation shall be obtained by the Most Responsible Practitioner (MRP) when required by Law, the Organization and Procedure Bylaws of the Interior Health Authority, *Medical Staff Bylaws* or *Medical Staff Rules*, or Department Policy.

SECTION 9 – RELEASE OF HEALTH RECORDS

9.1 Health Records are those documents compiled by the medical and professional staff of the Interior Health Authority to document care provided to patients/residents. Health Records may be facility based or community based. Health Records referred to in the *Medical Staff Bylaws*, Rules and policies shall mean facility-based records. Community based records will be referred to specifically by that terminology. Members of the Medical Staff involved in patient care shall be responsible for the preparation and legibility of their component of the health record.

9.2 Health records are owned by the Interior Health Authority and are not to be removed from a facility without the permission of management. Health records are to be retained and stored in the Health Information Management Services unless otherwise approved by the CEO or delegate. Community based health records shall be retained and stored, in accordance with formal guidelines.

9.3 Community based health records may travel with the patient, family or caregiver during the provision of care.

9.4 All previous Interior Health Authority records of any patient shall be available at the facility where the patient has received care to a practitioner currently involved in the care of that patient.

9.5 Access to copies of the health record is restricted by law, and can be obtained only by:

- the Coroners' office upon presentation of a warrant to seize
- a patient's request for their own records in accordance with Freedom of Information and Protection of Privacy (FOIPP) legislation
- court order or subpoena
- the patient's written authorization for release of information to a third party in accordance with FOIPP legislation
- the written request by a patient's physician for transfer of medical treatment and patient care
- the request of the hospital solicitor
- the written request of the College of Physicians & Surgeons of British Columbia, College of Dental Surgeons of British Columbia, College of Midwives of British Columbia, or College of Registered Nurses of British Columbia in accordance with applicable legislation
- the written request of a Department Head, Chief of Medical Staff or Medical Director for the purpose of peer review
- practitioners conducting a research study approved by the Interior Health Authority
- practitioners and hospital staff carrying out medical quality assurance, medical audits and utilization

- authorization of the appropriate Department Head, Medical Administrator or Director of the Continuing Medical Education Program for educational purposes
- resident staff involved with care of the patient
- a Review Panel under the Mental Health Act
- other legislated Acts and Statutes as may be enacted requiring access to health records

9.6 At no time should a practitioner make a copy of a patient's record. All requests for copies of patient records are to be handled by health records staff.

SECTION 10 – QUALITY ASSURANCE, QUALITY IMPROVEMENT AND PEER REVIEW

Quality Assurance (QA), Quality Improvement (QI) and peer review are processes which ensure that appropriate standards and patterns of medical care are created and maintained throughout the Interior Health Authority. Under the HAMAC, RMACs, and LMACs, each Medical Staff Department, Division and Section is responsible for establishing an adequate system for Quality Assurance (QA), Quality Improvement (QI) and peer review supported by Interior Health Authority's resources. All such committees are protected under Section 51 of the *Evidence Act of British Columbia*. Committees established for this purpose may request a staff member to respond to concerns about a case or cases under review.

10.1 If the committee requires a staff member to provide a formal written response the following procedure shall be followed:

(a) The chair of the committee shall detail the concerns in writing to the member

(b) The member, after the complete health record is available, shall respond in writing within a reasonable time period designated by the chair of the committee

(c) After review of the written response, the member may be required to attend a committee meeting to address issues to the committee's satisfaction

10.2 Failure of the member to provide a written response or to appear at a committee meeting when requested as described in Section 10.1 shall be reported to the Senior Medical Administrator (VP Medicine), Executive Medical Director, Department Head or delegate. After review, the Senior Medical Administrator (VP Medicine), on behalf of the Board of Directors, may direct appropriate educational, disciplinary or other corrective action which may include suspension of the member's privileges, in whole or in part, until the failure has been resolved. If the member again fails to appear at the designated committee meeting, the suspension will be re-instituted until the committee's requirements are satisfied.

10.3 If the committee believes that the member would benefit from educational, disciplinary or other corrective action, their recommendation will be directed to the relevant Department, Division or Section Head or the Chief of Medical Staff who, in turn, shall advise the committee of the results of the corrective action. The Executive Medical Director shall be advised of all recommendations for corrective action and of all results of that action.

SECTION 11 - ORGAN DONATION AND RETRIEVAL

The Interior Health Authority and its Medical Staff will cooperate with the British Columbia Transplant Society in supporting the provincial program for organ donation and retrieval.

11.1 Membership and Appointment

Temporary privileges may be granted, by the Board of Directors through the CEO or delegate, to physicians for situations such as organ retrieval.

11.2 Responsibility for Patient Care

11.2.1 In the event of organ donation, responsibility for the maintenance of the physiological status of the organ donor may be transferred, at the discretion of the Most Responsible Practitioner (MRP), to a physician member of the Organ Retrieval Team.

11.2.2 Consent for organ and tissue donation shall be validated through the British Columbia Transplant Society Registry or obtained through the patient's next of kin in accordance with the *Human Tissue Gift Act* and its *Regulations*.

11.2.3 Organ donation, after the declaration of neurological death, requires the Most Responsible Practitioner (MRP) to transfer responsibility to the Organ Retrieval Team. Standard protocols available from the Organ Retrieval Team may be followed and orders may be given to a registered nurse or a respiratory therapist for the maintenance of the physiological status of the donor.

SECTION 12 - DELEGATION OF A MEDICAL ACT

The process of delegation to other health care professionals must be consistent with the *Health Professions Act*. The Board of Directors must approve the list of delegated medical acts before they can be performed within the facilities and programs of the Interior Health Authority. Members of the Medical Staff may delegate certain functions in accordance with the following:

12.1 Delegation is required for reserved acts that fall outside the scope of practice of the receiving health professional.

12.2 Delegated medical functions are identified by mutual agreement among the representatives of the Medical Staff and the Professional Practice Office.

12.3 Delegated medical reserved acts are recommended to the Leader of Professional Practice and Nursing and approved to go forward through the external process by the HAMAC.

12.4 The request for delegation of the reserved act is then forwarded to both the College of Physicians and Surgeons of British Columbia and the regulatory body of the receiving discipline for approval that the reserved action is appropriate for delegation.

12.5 Even when the two regulatory bodies agree that the reserved act may be delegated, the decision to delegate remains with the individual delegating physician and the decision to accept the delegation remains with the individual receiving health professional.

12.6 A delegating physician with relevant expertise must ensure that the required knowledge and skills are appropriately taught, and confirm that the receiving health professional has the competence to perform the reserved act.

12.7 Written instructions must be provided for the delegated act.

12.8 The delegating physician and the receiving health professional are jointly responsible for ensuring that ongoing competence is maintained through mechanisms such as continuing education, experience, re-evaluation and retraining.

12.9 Professional Practice Leaders must ensure that records of health professionals qualified to perform delegated medical acts are maintained.

SECTION 13 - PRONOUNCEMENT OF DEATH, AUTOPSY AND PATHOLOGY

13.1 A physician member of the Medical Staff or registered nurse must pronounce death.

13.2 No autopsy shall be performed without an order of the Coroner or the consent of the legal next of kin or legally authorized agent of the patient (the Executor of the patient's estate or the Public Trustee). Where a minor is in the custody of the Province, the Director of Child Welfare shall provide consent.

13.3 In appropriate cases, the Most Responsible Practitioner (MRP) shall make all reasonable efforts to obtain permission for the performance of an autopsy.

13.4 All tissue or material of diagnostic value shall be sent to the Department of Pathology.

13.5 Pathology specimens including body tissues, organs, material and foreign bodies shall not be released without due authorization of the Head of the Department of Laboratory Services or delegate.

13.6 A physician member of the Medical Staff shall complete the medical certificate of death or stillbirth.

13.7 Deaths shall be reported to the Coroner in accordance with the requirements of the *Coroner's Act.*

SECTION 14 – RESIDENTIAL CARE

Medical care of residents in Interior Health Authority Long Term Care facilities differs in many aspects from medical care provided to patients in an acute care setting. Those differences are recognized in this section.

14.1 Admission, Transfer and Discharge of Residents

14.1.1 Every resident of a residential care facility shall be attended by a member of the Medical Staff who has admitting privileges at the residential care facility and who has primary responsibility for the care of the resident.

14.1.2 Prior to admission of a resident, the Most Responsible Practitioner (MRP) shall submit a legible, complete and updated medical record as required by the facility.

14.1.3 The Most Responsible Practitioner (MRP) shall note special precautions regarding the care of the patient on the order sheet in the patient's record at the time of admission (e.g. infectious disease, emotional disturbance, etc.)

14.1.4 Prior to admission, the practitioner shall assess the resident with regard to the risk of tuberculosis or other communicable disease which may pose a risk to staff or other patients and act in accordance with Provincial guidelines.

14.2 Resident Care

14.2.1 The Most Responsible Practitioner (MRP) shall visit the resident whenever clinically indicated.

14.2.2 The Most Responsible Practitioner (MRP) or delegate shall act according to the urgency of the situation when informed that, in the opinion of the nurse in charge, the condition of the resident has changed significantly,

14.2.3 Progress notes shall be documented at each visit.

14.2.4 All orders for medical treatment shall be legibly written and signed by a practitioner with Medical Staff privileges or a nurse practitioner. An order for medical care may be dictated over the telephone to a registered nurse or licensed practical nurse. An order dictated over the telephone shall be written over the name of the ordering practitioner and be signed by the person to whom they are dictated. Such orders shall be signed by the ordering practitioner as soon as possible. Orders on an Interior Health Authority physician order form may be faxed if signed by a medical practitioner.

14.2.5 Orders pertaining to other professional disciplines, e.g. occupational therapist, physical therapist, dietician, pharmacist, etc., may be given by the medical practitioner to a member of that discipline who shall write the orders on the Physicians Order Sheet. Such orders shall be signed by the ordering practitioner as soon as possible.

14.2.6 The Most Responsible Practitioner (MRP) or nurse practitioner shall carry out a Drug Review every 180 days or more frequently, if necessary, in collaboration with the medical coordinator, pharmacist or nurse, as appropriate. Medications shall be re-authorized every 180 days by updating and signing the drug profile or rewriting drug orders on the order sheet.

14.2.7 All orders for controlled drugs and antibiotics shall be written with a stated limit as to the number of doses, or the hours or days of administration. Telephone orders for controlled drugs shall be countersigned by the ordering practitioner within seven days. For drug orders written without such dosage or time limit, an automatic stop order shall be in effect.

14.2.8 The Most Responsible Practitioner (MRP) or nurse practitioner should attend interdisciplinary conferences to discuss and plan resident care. In the absence of the Most Responsible Practitioner (MRP), the Medical Director of the residential facility (if applicable) may make recommendations regarding care to the multidisciplinary team and submit the recommendations to the Most Responsible Practitioner (MRP) for approval.

14.2.9 Directives for care (level of intervention and resuscitation orders) must be completed on admission and updated as clinically indicated and at least annually.

14.2.10 In the event of an expected death, the Most Responsible Practitioner (MRP) may transfer the responsibility for "pronouncement of death" to a registered nurse in charge of the resident's care, provided the Most Responsible Practitioner (MRP) has visited the resident within the previous 30 days and documented on the resident's chart that death may be expected shortly. In accordance with the Coroner's Act, in the event of an unexpected death, death due to unnatural cause, or death with unusual circumstances, the Most Responsible Practitioner (MRP) or delegate is required to attend for the purpose of "pronouncement of death" and to review the circumstances surrounding the death. Completion of a "Certificate of Death" remains the responsibility of the Most Responsible Practitioner (MRP) in all circumstances. Physicians pronouncing death shall record the time, date and cause of death (if known) on progress notes.

14.2.11 The Most Responsible Practitioner (MRP) or delegate shall notify the Coroner of deaths that require notification under the Coroner's Act.

14.2.12 The Most Responsible Practitioner (MRP), nurse practitioner or delegate shall obtain a consultation when appropriate in all cases in which the diagnosis is obscure or when there is doubt regarding investigation or therapy. Where a consultation is required urgently and the Most Responsible Practitioner (MRP) or delegate is not available, the Medical Coordinator, the Medical Director of the residential care facility or a Senior Medical Administrator may authorize a consultation.

14.2.13 Practitioners requested to see patients in consultation shall be members of the Interior Health Authority Medical Staff or Allied Health Staff and shall provide a written report for the resident's chart.

14.2.14 Dentists treating residents shall enter in the resident's health record a description of every dental treatment or procedure performed immediately following the provision of care.

14.3 Health Records

14.3.1 A complete medical history and physical examination should be provided by the Most Responsible Practitioner (MRP) for each resident prior to admission.

14.3.2 The admission history shall include:

- a list of current diagnoses and medical problems
- past medical problems, illnesses, surgery
- allergies and drug sensitivities
- a list of current medication, including all over-the-counter and "alternative" medications sanctioned by the Most Responsible Practitioner (MRP)
- a record of a recent physical examination (performed within the previous three months)
- a mental status assessment
- results of appropriate laboratory tests
- a management plan including drug orders
- a summary or copies of consultant reports

14.3.3 Progress notes shall be documented at each visit and shall be sufficient to describe changes in the resident's condition, reasons for change of treatment and outcome of treatment.

14.3.4 Within 14 days following the death or discharge of a resident, the Most Responsible Practitioner (MRP) shall complete and sign the resident's discharge summary stating the final diagnosis therein.

SECTION 15 - ORGANIZATION OF THE MEDICAL STAFF

Article 7 of the *Medical Staff Bylaws* provides that the Board of Directors upon the advice of the HAMAC shall organize the Medical Staff into Departments, Divisions and Sections as warranted by the professional resources of the Medical Staff Departments shall meet a minimum of four times per year. Minutes shall be kept of each meeting and shall include a record of attendance. Minutes shall be available to the Senior Medical Administrator (VP Medicine) and to the HAMAC on request.

The purpose of organizing the Medical Staff into Departments includes the following:

- to support quality improvement, quality assurance and peer review
- to participate in strategic practitioner resource planning
- to promote professional development and continuing medical education
- to support the Medical Staff through specific activities and programs to promote practitioner well being

The health and well-being of Medical Staff members will be a focus of each clinical department. Department Heads and Chiefs of Medical Staff will work with the Senior Medical Administrator (VP Medicine) and the Executive Medical Directors to:

- promote health and wellness amongst Medical Staff
- encourage a healthy and respectful workplace
- establish mechanisms to identify practitioners at risk of mental illness, substance dependency or severe professional fatigue
- develop strategies and supports for timely respectful intervention for medical professionals with compromised health and well being
- assist in the development of Medical Staff health programs

- establish mechanisms to report impaired practitioners, to ensure that such practitioners promptly cease practice and to support recovering practitioners when they are deemed ready to resume patient care responsibilities

15.1 Medical Staff Departments in the Interior Health Authority shall be:

- Anaesthesia
- Dentistry
- Diagnostic Imaging
- Emergency Medicine
- Family Practice
- Laboratory Medicine
- Medicine
- Midwifery
- Nurse Practitioner
- Obstetrics and Gynecology
- Pediatrics
- Psychiatry
- Surgery

15.1.1 Existence of Medical Departments, Divisions and Sections shall be determined on a site by site basis. Departments may be organized and terms of reference defined at the level of the Health Authority, Region (Health Service Area) or individual facility.

15.2 Department Heads

15.2.1 Each Department Head shall be a member of the Active Medical Staff of that department and shall be appointed by the Board of Directors on the advice of a Selection Committee as defined in Section 14.6 of these Rules. Department Heads shall be selected on the basis of qualifications of training, experience and demonstrated ability in clinical skills, teaching and administrative activities.

15.2.2 The term of appointment for a Department Head shall be 2 years. The Board of Directors may reappoint a Department Head for 2 additional terms on the recommendation of the HAMAC following appropriate performance review as defined in Section 15.7 of these Rules.

15.2.3 The provision of remuneration by the Interior Health Authority in any form for Department Heads will be at the prevailing rates and as negotiated between the Medical Staff member(s) concerned and the Board of Directors through the CEO and Medical Administration. Medical Staff members have the right to be represented by Counsel or the British Columbia Medical Association (BCMA) if they so choose.

15.3. Responsibilities of Department Heads

15.3.1 Direct the organization of the Medical Staff assigned to their Department so as to assure the quality of medical care.

15.3.2 Develop with the members of the department, standards of clinical practice for the department and ensure that the department members work within established standards.

15.3.3 Ensure that programs for the Continuing Medical Education of department members are established.

15.3 4 Establish a quality assurance/quality improvement structure and program within the department, which carries out the functions of review, evaluation and analysis of the quality of medical care and utilization of hospital resources.

15.3.5 Ensure that all members of the department are aware of the professional standards for medical care as set out in the *Medical Staff Bylaws*, Rules and policies.

15.3.6 Advise the HAMAC and RMACs with respect to the quality of medical care provided to patients and the level of compliance with professional standards of medical care by all members of the department.

15.3.7 Develop and recommend policies concerning the delineation of clinical and procedural privileges for department members to the HAMAC and RMACs.

15.3.8 Review and make recommendations to the Medical Staff Human Resource Planning and Credentials Committee concerning the annual review and assignment of privileges to all members of the department.

15.3.9 Review with the department and the Executive Medical Director the personnel requirements of the Department and recommend to the Medical Staff Human Resource Planning and Credentials Committee a plan for the Department.

15.3.10 Ensure that all new department members are appropriately oriented to facilities, programs and services prior to commencement of duties.

15.3.11 Advise the HAMAC regarding the appointment of Division and Section Heads.

15.3.12 Convey the advice, opinions and duly passed motions of Department members to the LMACs, RMACs and HAMAC and, in reverse, communicate relevant information from the HAMAC RMACs and LMACs and the Board of Directors of the Interior Health Authority, and Administration to the members of the Department

15.3.13 Accept the duty to identify department members at risk and to enable the referral of such at risk members to support programs of practitioner health and well-being as an aid to recovery and re-entry into professional practice.

15.3.14 Appoint an Assistant Department Head who shall assume the responsibilities of the Department Head in the absence of the Department Head.

15.4 Division Heads

15.4.1 Division Heads shall be appointed annually by the Department Head after consultation with Division members.

15.4.2 The responsibilities of the Division Head shall be similar but subordinate, to those of the Department Head and shall be focused on the specific clinical activities of the Division.

15.4.3 The Division Head shall report to the Department Head on all clinical, educational, research and administrative matters within the Division.

15.4.4 The Division Head shall be an Active member of the Medical Staff, and selected on the basis of qualifications of training, experience and demonstrated ability in clinical, teaching and administrative activities.

15.5 Section Heads

15.5.1 Section Heads shall be appointed by the Division Head after consultation with Section members and the Department Head.

15.5.2 The responsibilities of the Section Head shall be similar, but subordinate, to those of the Division Head and shall be focused on the specific clinical activities of the Section.

15.5.3 The Section Head shall report to the Division Head on all clinical, educational research and administrative manners within the Section.

15.5.4 The Section Head shall be an Active member of the Medical Staff and selected on the basis of qualifications by training, experience and demonstrated ability in clinical and administrative activities.

15.6 Process for Appointment of a Department Head

When a vacancy exists in a position of Department Head and that vacancy is to be filled by a regular appointment by the Board of Directors, a Search Committee may be convened. The Search Committee shall report its recommendations to the R MAC. The RMAC shall recommend to the HAMAC and the Board of Directors the appointment of a new Department Head following consideration of the Search Committee's recommendations.

15.7 Process for Review of a Department Head

Department Heads are appointed for a term of two years. The Senior Medical Administrator (VP Medicine) and the Executive Medical Director shall be responsible for reviewing the performance of Department Heads. In the second year of appointment, a review committee may be convened to formally assess the performance of each Department Head and report its recommendations to the LMAC and RMAC. This report shall include a recommendation regarding the re-appointment or non re-appointment of the Department Head for a further two year term.

15.8 Suspension or Termination of a Department Head

The Board of Directors may, on the recommendation of the HAMAC, or in its sole discretion, suspend or terminate the appointment of any Department Head. Prior to such suspension or termination, reasonable notice shall be given to such Department Head and to the HAMAC.

15.9 Clinical Program Directors

Clinical Program Directors, together with their respective Administrative Program Managers, lead and facilitate a collaborative inter-professional environment to enhance patient/client-focused service. The Clinical Program Director reports to the Senior Medical Administrator (VP Medicine) or Executive Medical Director or delegate for matters of medical quality of care and professional standards and to the CEO or Vice President or delegate for operational aspects of the program.

As part of their overall duties, Clinical Program Directors shall:

- work in collaboration with other Program Directors and Department Heads to ensure that all programs support the Interior Health Authority strategic plan
- support the development of program management strategies with a focus on interdisciplinary collaboration and decision making
- ensure that policies and procedures are established for the delivery and evaluation of services offered within the program/core service
- work in collaboration with Medical Staff and Department Heads on the development and promotion of medical standards, education and research
- provide leadership and direction for quality improvement, utilization management and risk management within the program
- conjointly plan Medical Staff recruitment, appointments and availability with Medical Staff Department Heads
- perform other related duties as assigned.

SECTION 16 - MEETINGS OF THE MEDICAL STAFF

16.1 Annual General Meeting

Medical Staff Associations are present in the various acute care facilities of the Interior Health Authority. At each facility with a Medical Staff Association, the Annual General Meeting shall be held every 12 months at which time officers shall be declared for the ensuing year. The President shall ensure a notice be sent to all members of the Medical Staff at least 14 days prior to the annual meeting announcing the time and place of the meeting. An annual report from the officers and committees shall be presented. Minutes of the meeting shall be kept.

16.2 Regular Meetings

16.2.1 Regular meetings of the Medical Staff shall be held semi-annually or more frequently as deemed appropriate by the President or officers of the Medical Staff.

16.2.2 The President shall post a notice for members of the Medical Staff at least 14 days prior to a regular meeting announcing the time and place of the meeting.

16.2.3 The CEO of the Interior Health Authority shall be given notice of each Medical Staff meeting and the CEO or a delegate shall attend all meetings of the Medical Staff.

16.2.4 Regular meetings shall inform the Medical Staff of actions recommended by the HAMAC, RMACs and LMACs

16.2.5 Department and committee reports may be presented at these meetings.

16.3 Special Meetings

16.3.1 A special meeting shall be called by the President of the Medical Staff or at the request of 25% of the members of the Medical Staff eligible to vote and shall be held within fourteen days of receipt of the request.

16.3.2 At a special meeting, no business shall be transacted except as explicitly stated in the notice calling the meeting.

16.3.3 The President shall ensure a notice is sent to members of the Medical Staff at least seven business days before the special meeting and shall contain the purpose of the meeting.

16.4 Attendance

Active and Provisional Medical Staff members should attend at least 50% of the regional or local Medical Staff meetings in a calendar year.

16.5 Quorum

A quorum shall be 25% of members eligible to vote.

16.6 Membership Dues

All members of the Medical Staff shall pay annual membership dues as applicable for their facility. Membership dues shall be determined by a vote at the Annual Meeting on the recommendation of the elected officers of the Medical Staff.

16.7 Medical Staff Executive Committee (optional for smaller facilities)

Purpose: To represent the interests of Medical Staff members as their elected representatives

Responsible to: The Medical Staff

Composition:

- President (chair)
- Vice-President
- Secretary-Treasurer
- Other members of the Medical Staff as decided by the elected officers

Term: One year

Quorum: A simple majority

Meetings: At least quarterly or at the call of the chair

Duties:

- To represent the concerns and opinions of the Medical Staff members to the HAMAC, the RMAC and to the Interior Health Authority

- To collect annual fees and administer Medical Staff funds
- To create and administer programs of interest to the Medical Staff members
- To meet at the call of the Chair to nominate a candidate to fill any position vacated during the term of office in accordance with Section 10.4 of the *Medical Staff Bylaws*.
- To ensure a fair and equitable system of voting for officers by all members of the Medical Staff through a mail-in ballot or similar process.
- To invite nominations from the members of the Medical Staff through a notice provided to each member at least one month prior to voting.
- To prepare a list of candidates for the elected positions of officers of the Medical Staff for the Annual Meeting of the Medical Staff. At least one person shall be proposed for each position.

SECTION 17 - DISCIPLINE AND APPEAL

The specific processes and procedures concerning discipline and appeal matters are outlined in Article 11 of the *Medical Staff Bylaws*.

17.1 General Considerations

In consideration of the need for the Board of Directors to be able to take remedial action including a reprimand, or restriction, modification, suspension or revocation of privileges, or a decision not to renew privileges, certain principles will be applied by the Medical Staff and administration in developing advice on such matters for transmission to the Board. The principles include:

17.1.1 Lawfulness - A disciplinary procedure must meet the criteria of procedural fairness as determined by the jurisprudence of the Court, and the provisions of relevant legislation and bylaws.

17.1.2 Efficiency - A procedure should allow the resolution of a problem in a timely fashion, without undue expense and administrative dislocation. The procedure should operate in a smooth and predictable way, while at the same time respecting the duty of fairness to the practitioner who is subject to the procedure.

17.1.3 Clarity - The process should be understandable and made known to all of the parties from the time when practitioners are initially given privileges.

17.1.4 Legitimacy - The process should be perceived as legitimate by all participants. In particular, the process should be seen as legitimate by the Medical Staff.

17.1.5 Timeliness - Proceedings should be concluded in a timely fashion in order to ensure protection of patients, and to ensure the member of the Medical Staff is not unfairly prejudiced by any long term uncertainty which could have adverse affects on the reputation and income of the member of the Medical Staff. Matters should be concluded in the shortest possible time compatible with the full and careful consideration of the issue. The time constraints dictated by legislation shall be respected.

17.1.6 Application of Standards of Practice

In order for an evaluation of a Medical Staff member's practice to be fair and reasonable, such evaluation must be made using standards of practice and professional behaviour established by the medical profession. It is expected that each clinical Department will develop standards of clinical practice and behaviour as required by Interior Health Authority policies, the *Medical Staff Bylaws*, Rules and Departmental policies.

17.2 Automatic Suspension

Further to Article 11.3.1 of the Interior Health Authority *Medical Staff Bylaws*, a member of the Medical Staff shall automatically have his/her privileges suspended under circumstances including, but not limited to:

- Abandonment of a patient admitted to an Interior Health Authority facility under the care of that member of the Medical Staff.
- The commission by the member of Medical Staff of a criminal offence related to the exercising of the member's privileges as evidenced by the laying of criminal charges.
- The provision of clinical care, the exercising of clinical privileges, or the fulfillment of contractual arrangements for the provision of patient care by a member of Medical Staff while impaired by drugs or alcohol.
- Failure to comply with Interior Health Authority *Medical Staff Rules* regarding the completion of health records as described in Section 5.3.7 of these Rules.

17.3 Procedure for Review of a Complaint against a Member of the Medical Staff.

17.3.1 A matter brought to the attention of a Department Head, Chief of Medical Staff or other person in authority from such sources as

- a department QA committee
- colleagues
- other professionals
- Medical Director
- an incident report
- a private informant

provided it is clearly documented, will be discussed between the practitioner and the Department Head or Chief of Medical Staff with disclosure of the complaints against the practitioner. If the complaint is without foundation or does not require corrective action, the matter is closed. If corrective action is required and agreed upon with a mechanism for review with clear parameters of expected improvement within a specified timeframe, the course of action will be documented with a copy being forwarded to the Executive Medical Director and the practitioner involved.

17.3.2 When corrective action is not agreed upon under 17.3.1, or where attempts at corrective action have failed, a meeting between the practitioner, the Department Head or Chief of Medical Staff, and the Executive Medical Director is held. Should the practitioner so wish, the President of the Medical Staff or other Medical Staff representative of the practitioner's choice may attend the meeting. The objective of this meeting is to review and, if appropriate, reinforce the directions set by the Department Head or Chief of Medical Staff in step one and to delineate further corrective action in the case of failure to improve. The meeting will be documented with all present receiving copies of all material and with copies lodged with the Senior Medical Administrator (VP Medicine).

17.3.3 Where the matter is not resolved at 17.3.2, the Senior Medical Administrator (VP Medicine) will be informed. A meeting of the appropriate LMAC and RMAC will be held. At this meeting or as early prior to the meeting as practicable, all relevant documentation is made available to the members of that MAC and to the practitioner in question. The practitioner is given the opportunity to be heard by the Committee. The RMAC, in consultation with the LMAC where appropriate will decide whether further action is required. If so, one of the following processes will occur:

(a) The practitioner will voluntarily agree to the recommended remedial action; or

(b) The RMAC will forward to the HAMAC its recommendations for corrective action which may include restriction, modification, suspension revocation or non-renewal of the practitioner's privileges within the Interior Health Authority. The HAMAC will then convene a special meeting within 30 days to consider the recommendation(s). The practitioner will be notified in writing of the recommendation(s), the date and time of the HAMAC meeting and be reminded of his right to be heard; or

(c) The Senior Medical Administrator (VP Medicine) may summarily suspend the practitioner in accordance with Article 11.2.1.1 of the *Medical Staff Bylaws*. In this circumstance, a special meeting of the HAMAC will be held in accordance with Article 11.2.1.5 of the *Medical Staff Bylaws*.

17.3.4 Any subsequent disciplinary recommendations made by the HAMAC will be presented to the Board of Directors whose decision is subject to the appeal procedures set out in Article 11.4 of the *Medical Staff Bylaws*.

17.4 Independent Review

Board of Directors Policy 3.15 *Safe Reporting*, provides that a review of the conduct of any person associated with the Interior Health Authority, including a member of the Medical Staff, may be initiated through the Director, Internal Audit.

This provides a means by which an individual can report perceived issues to an independent authority in special circumstances where he/she has sound reason to believe that the existing processes are not appropriate or have failed to deal with the concerns expressed.

This policy is intended to supplement and does not replace the established processes for the reporting, investigation and disposal of complaints against a member of the Medical Staff as set out in 17.3 above.

The review of an allegation involving a member of the Medical Staff will be conducted in consultation with the Senior Medical Director and, in cases where the cancellation, suspension, restriction or non-renewal of privileges may be warranted, the recommendation will be forwarded jointly to the Chair of the Board of Directors and to the CEO who will involve the HAMAC in accordance with the Provisions of Article 11 of the *Medical Staff Bylaws*. The Board of Directors will give due weight and consideration to the recommendation of the HAMAC in making its decision.

SECTION 18 – MEDICAL STAFF POLICY MANUAL

18.1 A Medical Staff Policy Manual will be maintained at such locations as may be required to allow ready access by all members of the Medical Staff of the Interior Health Authority.

18.2 The Manual will document:

1. The *Medical Staff Bylaws*
2. The *Medical Staff Rules*
3. Medical Staff Administrative Policies and Guidelines
4. Rules established by the HAMAC
5. Board of Directors policies affecting the Medical Staff, and
6. Board of Directors policy in respect to delegated medical acts that can be performed within the facilities and programs of the Interior Health Authority

18.3 The Manual may, in addition, be published on the Interior Health Authority website.