QUINTE HEALTHCARE CORPORATION

GENERAL RULES AND REGULATIONS

Approved by the Board of Directors – September 27, 2000

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The following are enacted and adopted as the Rules and Regulations of the Professional Staff of the Quinte Healthcare Corporation:

DEFINITIONS

For the purposes of these Rules and Regulations:

(1) ***"Board"*** means the governing body of the Corporation, being its Board of Trustees.

(2) ***"Chief of Staff"*** means the person responsible to the Board for the quality of medical care in the Corporation as appointed by the Board.

(3) ***"Corporation"*** means Quinte Healthcare Corporation.

(4) ***"Designated Responsible Professional Staff Member"*** means the physician, dentist, or midwife designated to be responsible for any department, division, service or program that may be established by the Corporation from time to time, as further described in the Medical By-Laws

(5) ***"Hospital"*** means Quinte Healthcare Corporation.

(6) ***"MAC"*** means the Medical Advisory Committee.

(7) ***"Medical By-Laws"*** means the Medical Staff/Dental Staff and Midwifery Staff By-Laws of the Corporation.

(8) ***"Midwifery Staff"*** means all midwives to whom the Board grants the privilege of attending patients in the Corporation.

(9) ***"Most Responsible Professional Staff Member"*** means the physician, dentist or midwife who co-ordinates the care of a patient.

(10) ***"Privilege"*** means a medical, dental or midwifery activity in the Corporation sanctioned by the Board.

(11) ***"Professional Staff Member"*** means all physicians, dentists, and midwives to whom the Board grants the privilege of attending patients in the Corporation.

(12) ***"Rules and Regulations"*** means policies and procedures governing the practice of medicine, dentistry, or midwifery in the Corporation generally, or in a particular department, division, service or program of the Corporation or at a particular site of the Corporation, which have been established by the Professional Staff as a whole or by a department, division, service, program or council, and approved by the Board on the recommendation of the MAC.

(13) ***"Site or Sites"*** means one or more of the hospital facilities operated by the Amalgamating Hospitals prior to the Amalgamation Date, as such may be altered by the Corporation from time to time.

(14) ***"Associate Staff Member"*** means all physicians, dentists, and midwives to whom the Board grants the privilege of attending patients in the Corporation for a probationary period.

PRINCIPLES OF PROFESSIONAL STAFF

RULES AND REGULATIONS

1. The Rules and Regulations are subordinate to the By-Laws of the Corporation.

2. Members of the Professional Staff must comply with the Rules and Regulations.

3. These Rules and Regulations are written pursuant to the requirements of the By-Laws of the Corporation and the Hospital Management Regulation, being Ontario Regulation 965 enacted pursuant to the *Public Hospitals Act*, as amended from time to time.

4. These Rules and Regulations shall not repeat By-Laws or statutory provisions.

5. These Rules and Regulations must be clearly written and specific to the needs and circumstances of the Professional Staff.

I General Rules

SECTION 1 – ENHANCED PEER REVIEW

1.1 On some occasions, a professional staff member may be required to undergo an enhanced peer review When any member of the Professional Staff 65 years of age or older applies for re-appointment, he or she shall be required to undergo an enhanced peer review by the Chief of Staff and the Designated Responsible Professional Staff Member, as appropriate (or, if the Professional Staff Member is the Designated Responsible Professional Staff Member, by an alternate person appointed by the Chief of Staff), which shall include a review of the following factors with each applicant for re-appointment:

(a) the type of application being made; i.e.,

(i) application for re-appointment;

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

(b) if requested, a current certificate of Professional Conduct from the College of Physicians and Surgeons of Ontario and a consent allowing the release of information from the registrar of the College;

(c) the name of the department, service, program or division 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 staff member's duty/obligations and quality of care provided at the reviewing facility;

(g) participation in continuing medical education programs in keeping with the standards of the respective Service Councils;

(h) ability to communicate with patients and staff;

(i) on call participation;

(j) staff and committee responsibilities;

(k) quality of care issues including, but not limited to, complications, infection rate, tissue and audit committee reports, utilization review, indicators developed by respective Service Councils, etc.;

(l) patient/staff complaints;

(m) ability to supervise staff;

(n) monitoring of patients;

(o) clinical record documentation;

(p) appropriate and efficient use of Hospital/Site resources;

(q) a record of any criminal convictions;

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

(s) Human Resource Plan and retirement plans;

(t) a willingness to participate in the discharge of staff obligations;

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

1.2 The requirement for an enhanced peer review will be determined based on the currently accepted review policy approved by the Medical Advisory Committee. The Chief of Staff, in consultation with the Chief of the Department and the Medical Advisory Committee will determine if an external or internal enhanced peer review is required.

SECTION 2 – MEDICAL RECORDS AND DOCUMENTATION

2.1 *Accuracy*:

All medical records and other documentation shall accurately reflect all diseases or conditions affecting a patient and shall accurately describe all procedures performed during the patient's stay.

2.2 *Medical Records*:

(a) The medical record is a record of the patient's stay in the Hospital/Site and is considered a major means of communication among health care practitioners. Medical records shall be written in a legible manner.

(b) A single stroke shall be drawn through any blank line/space to prevent further entries. Erasures or obliterations of incorrect entries are unacceptable. Incorrect entries shall be indicated by a single stroke drawn through them, and shall be signed or initialled and dated by the physician.

(c) The medical record shall contain sufficient information to indicate what progress was made by the patient, what problem(s) had developed with the patient, the assessment of the problem(s) and the care that was rendered.

(d) The admitting Professional Staff Member shall be responsible for documenting the medical history, the results of the physical examination and the provisional diagnosis of the patient's medical condition upon admission.

(e) Each Professional Staff Member shall be responsible for documenting the portion of the patient care that he or she has rendered.

(f) Medical records should be completed within 14 days after the records are made available in the physicians' dictating area by the Medical Records Department.

(g) Further to the *Public Hospitals Act (O. Reg. 965, Section 22)* all medical records are the property of the Hospital. Members of the Professional Staff shall not remove medical records (or notes, charts and other material relating to patient care) from the Hospital or Site without the prior approval of the Board, and in keeping with the Hospital's/Site's policies and procedures pertaining to the copying and access to medical records.

2.3 *Pre-admission Documentation*:

Where documentation on a pre-admission history, physical examination and provisional diagnosis is accepted and put in the medical record, the Most Responsible Professional Staff Member shall be responsible to date, sign and note in the medical record after admission that the pre-admission documentation accurately reflects the patient's current clinical condition. If there is any change, it should be noted in the medical record.

2.4 *Repeat Visits*:

When a patient returns to the Hospital/Site 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 patient's medical record.

2.5 *Progress Notes*:

(a) Progress notes shall be written to accurately reflect the clinical condition of the patient. For acute care patients this will vary from several times a day to daily or every two to three days, based on the acuity of the patient's condition.

(b) For complex continuing care patients, a minimum of one progress note every 7 days is required.

(c) Professional Staff Members shall accurately enter all diseases or conditions on the medical record and clearly describe all procedures. Physicians (and dentists or midwives as applicable) shall provide full descriptions of the diagnoses made and procedures performed during the patient's stay in order to ensure the validity of statistical data for planning, research and funding purposes.

2.6 *Discharges*:

(a) Professional Staff Members shall assign diagnoses using the following categories:

(i) most responsible for admission;

(ii) primary diagnosis;

(iii) secondary diagnoses; and

(iv) complications.

(b) Professional Staff Members shall assign the principal procedure as the procedure considered to be the most significant during the Hospital stay.

(c) When a patient insists upon leaving the Hospital/Site against the advice of the Most Responsible Professional Staff Member, he or she shall be warned of the consequences of doing so. If the Professional Staff Member is present, a statement describing the circumstances shall be entered by the Professional Staff Member in the patient's medical record and the patient shall be asked to sign a release form.

(d) The Most Responsible Professional Staff Member or designate shall write the discharge order. The Most Responsible physician shall be responsible for the completion of the discharge summary on all admitted patients.

2.7 *Consent*:

If refusal by a parent or a person having lawful custody appears to the Most Responsible Professional Staff Member to be detrimental to the patient, the Chief of Staff or the Chief Executive Officer shall be informed.

2.8 *Orders for Treatment*:

(a) Every order for patient treatment or diagnostic procedure shall (except as provided in subsection (b) below) be in writing and shall be dated and authenticated by the Professional Staff Member giving the order.

(b) A Professional Staff Member may dictate an order for treatment or for a diagnostic procedure to an appropriate Hospital/Site health care professional via telephone, or face to face in an urgent situation.

(c) Where an order for treatment or for a diagnostic procedure has been dictated via telephone, or face to face in an urgent situation, the order shall subsequently be authenticated by the ordering Professional Staff Member or by the Most Responsible Professional Staff Member within 48 hours or next attendance pursuant to Section 2.10.

2.9 *Admitting Reports*:

(a) The admitting Professional Staff Member or designate shall, within 24 hours after each patient is admitted to the Hospital/Site, ensure that an admitting note (which sets out clearly the reason for admission of the patient) is entered in the medical record of the patient and authenticated.

(b) Subsection (a) above does not apply where a report referred to in subsection (c) (iv) below is entered in the medical record of the patient within 24 hours after the patient is admitted to the Hospital/Site.

(c) A member of the Professional Staff shall, within 72 hours after each patient is admitted to the Hospital/Site:

(i) take a medical history of the patient;

(ii) conduct a physical examination of the patient;

(iii) make a provisional 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 provisional diagnosis of the patient within 72 hours.

(d) Where a patient is admitted to the Hospital/Site for treatment by a dentist, the most responsible dentist shall (within 24 hours of the admission of the patient):

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

(ii) make a dental and oral examination of the patient;

(iii) make a provisional 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 provisional diagnosis and a statement of the proposed course of dental treatment for the patient.

(e) Where a patient is admitted to the Hospital/site for dental surgery, the attending dentist shall ensure that subsections (c) and (d) above have been tended to prior to commencing surgery.

2.10 *Authentication of Dictated Reports*:

(a) Dictated reports may be authenticated as follows:

(i) once arranged, authentication of dictated reports shall be performed when the Professional Staff Member accesses the Hospital's/Site's central dictation system with his/her personal identification number and states his/her name;

(ii) the authentication process applies to all dictation done through the central dictation system relating to inpatients, emergency patients, medical day stay patients and surgical day stay patients;

(iii) authentication of a dictated report shall be based upon verification by a Hospital/Site transcriptionist at the time of report transcription;

(iv) if the Professional Staff Member identification number entered into the dictation system and the Professional Staff Member name verbally given correspond with the reference file maintained in the Hospital's Health Records department, the report shall be labelled "**Authenticated**" in the bottom right hand corner;

(v) if the procedure for authenticating documents is not carried out correctly (i.e., if the Professional Staff Member does not identify himself/herself at the beginning of each report or the Professional Staff Member number or name does not correlate), the report shall not be identified as authenticated;

(vi) authenticated reports shall not be routed to the Professional Staff Member for a signature; and

(vii) Professional Staff Members are responsible for proofreading transcribed reports and for notifying a transcriptionist of errors/omissions as soon as possible.

(b) Professional Staff Members acknowledge the necessity for maintaining the secrecy of their identification number, and accept full responsibility for the form and content of whatever is transcribed following authentication. A report is deemed to have been reviewed as soon as it has been authenticated.

2.11 *Surgery*:

Every surgeon who performs a surgical operation on a patient in the Hospital/Site shall prepare, or cause to be prepared by a person qualified to do so, within 24 hours, and authenticate, a written description of the operative procedure and the findings and diagnosis made at the operation.

2.12 *Death Certificate*:

(a) When a patient dies in Hospital, the Most Responsible physician, or delegate, shall cause a copy of the medical certificate of death to be filed in the medical

record pertaining to the patient by the very next morning after the death of the patient; and

(b) Where a coroner is required to complete the medical certificate of death and the coroner does not provide the Most Responsible physician with a copy of the medical certificate of death, the Most Responsible physician shall complete the appropriate forms and cause a copy of the report to be filed in the medical record pertaining to the patient.

SECTION 3 – COMPLIANCE WITH HEALTH RECORD DEPARTMENT POLICY AND PROCEDURE

3.1 *Compliance*:

(a) All members of the Professional Staff must be familiar with and comply with the Health Records Department policy and procedure with respect to medical records.

(b) All members of the Professional Staff who are delinquent with respect to compliance with the Health Record Department policy and procedure shall be subject to loss of Privileges.

3.2 *Completion of Records*:

Professional Staff Members are required to complete all medical records related to their patients within 14 days of such records being made available to them for completion.

3.3 *Admitting Privileges*:

The Chief Executive Officer may, upon the recommendation of the Chief of Staff, suspend the admitting Privileges of any Professional Staff Member who, without reasonable justification, has failed to complete any medical record(s) made available to them during the preceding calendar month(s).

3.4 *Suspension Procedures*:

The following suspension procedures shall apply:

(a) Incomplete charts will be filed in the Physician's Incomplete area by day outstanding and will be reviewed every two weeks. All charts that have been available for completion for more than 7 days will be identified.

(b) A list of incomplete records by day outstanding will be placed in the appropriate Professional Staff Members' mailboxes (excluding out of town Professional Staff Members) with a notation stating that the records must be completed within 14 days or their admitting Privileges will be suspended.

(c) Out of town Professional Staff Members will receive a telephone call or a fax, notifying them of their incomplete charts. They are included in the suspension procedure.

(d) Two days before suspension, all Professional Staff Members who have not completed their charts will receive a call from Health Records, reminding them that their admitting Privileges will be suspended in two days.

(e) On the suspension day a list of Professional Staff Members who have lost their Privileges and their alternates will be sent to:

(i) The Chief of Staff;

(ii) The Designated Responsible Professional Staff Member;

(iii) Nursing Units;

(iv) Emergency Department;

(v) Operating Rooms;

(vi) Administration; and

(vii) Admitting.

This list will be used to ensure that the Professional Staff Member is restricted in accessing hospital services.

(f) Once the suspended Professional Staff Member has completed his or her outstanding overdue charts and the appropriate suspension period is complete, all areas notified pursuant to paragraph (e) above will be notified by Health Records of the re-instatement of Privileges, and a letter will be sent to the Professional Staff Member on the next working day, informing him/her of his/her re-instatement.

(g) Those Professional Staff Members who are on vacation will be exempt from suspension, provided that they have notified Health Records prior to leaving for their vacation.

(h) It is the responsibility of the Chief Executive Officer or the Chief of Staff or designate to re-instate Privileges in extenuating circumstances without the completion of medical records.

(i) Medical records unavailable to Professional Staff Members for completion will not be considered delinquent, and the completion date will be extended.

3.5 *Coverage Arrangements:*

A Professional Staff Member whose admitting Privileges have been suspended shall retain the privilege of attending those patients admitted prior to the effective date of suspension of Privileges, but shall be required to arrange with another appropriate Professional Staff Member to admit and assume responsibility for care of any patient for whom admission is sought during any suspension of such individual's Privileges.

SECTION 4 – CONTINUITY OF MEDICAL COVERAGE

There shall be policies written to ensure that adequate medical coverage is maintained.

4.1 *Most Responsible Professional Staff Member*:

There shall be a Most Responsible Professional Staff Member identified for each patient.

4.2 *Request for Consultation*:

The Most Responsible Professional Staff Member shall, when asking for a consultation, indicate whether the request is for an opinion only, for shared care, or for total transfer of responsibility, and this shall be noted on the medical record of the patient.

4.3 *Rules for the Most Responsible Professional Staff Member:*

The Most Responsible Professional Staff Member shall:

(a) provide daily care to the patient and make a minimum of 2 visits per week to the complex continuing care unit, and daily visits for acute patients (or as appropriate), or by a delegate or substitute;

(b) be available and respond promptly for continuing medical problems;

(c) maintain communication with the Most Responsible Professional Staff Member(s) "on call" for him/her. Any physician who is "on call" for the most responsible physician must have admitting privileges at the Hospital;

(d) provide adequate coverage of his/her patients in the hospital by being available himself/herself or having available through his/her office, a qualified substitute with whom prior arrangements for patient coverage have been made;

(e) ensure that where such substitution is to cover a period greater than forty-eight (48) hours, the responsibility of patient care must be transferred to the substitute or another member of the Professional Staff who shall be designated as the patient's new Most Responsible Professional Staff Member. This transfer shall be recorded in the patient record, or according to written policy developed by each Service Council (Appendix A);

(f) ensure appropriate response to new urgent problems;

(g) maintain either verbal or written necessary communication with the other physicians as appropriate;

(h) communicate with the family;

(i) write progress notes to accurately reflect the clinical condition of the patient. This will vary from several times a day to daily or every 2 or 3 days; and

(j) ensure that where a patient is admitted without a local family physician, and is not admitted under the care of a specialist, the patient shall be admitted under the care of a member of the Professional Staff on the roster. This member of the Professional Staff shall be the Most Responsible Professional Staff Member for the patient for the course of the patient's hospitalization.

4.4 *Emergency Physician Staffing:*

(a) The Chief of the Department of Emergency Medicine shall oversee the Emergency Department.

(b) Physicians with privileges to provide emergency care shall staff the Emergency Department with 24 hour, 7 days per week continuous coverage in accordance with a schedule created by, or caused to be created by, the Chief of the Department of Emergency Medicine.

(c) At the time of application for appointment or reappointment, physicians with privileges to provide emergency care shall commit to a minimum number of shifts that they will provide.

(d) Where numbers of physicians with privileges to provide emergency care in the Emergency Department are too low to provide continuous coverage, these physicians shall be flexible in terms of timing of shifts to allow appropriate scheduling which can accommodate additional locum personnel to provide continuous coverage.

4.5 *On-Call:*

(a) All Professional Staff Members shall participate in an on-call and second on-call roster, once established, and where medical manpower permits.

(b) All departments are expected to provide 24 hours per day, 7 days per week on-call coverage where the number of physicians in the Department makes this feasible, and are expected to provide a schedule.

(c) All members of the Professional Staff shall maintain a call schedule and shall not be obligated to provide more than one in 5 days, and one in 5 weekends in the average 365-day year. Personal or Statutory holidays are not excepted from call day-total requirements.

(d) All members of the Professional Staff in a Department shall share equally with all other department members in call obligations for weekdays and weekend days.

(e) When on call, members of the Professional Staff are expected to be available immediately by telephone and to attend within 30 minutes of being paged to attend.

4.6 *Leave of Absence:*

Where a Professional Staff Member is on a leave of absence during the time for making an application for re-appointment to the medical staff, he/she will not be required to make his/her application for re-appointment until his/her return from the leave.

4.7 *Vacation*:

(a) A vacation schedule shall be developed by the Designated Responsible Professional Staff Member, or designate, of each program, service, division or department, to ensure appropriate medical coverage and continued functioning of the Hospital during vacation times.

4.8 *On Call Rota*:

(a) The Designated Responsible Professional Staff Member of each department, division, service or program, shall produce and post their respective daily duty rosters before the first of each calendar month. Each Professional Staff Member has the duty to provide services as described in the Medical By Laws, including the obligation to provide on call coverage for speciality services. Access to Corporation resources, including access to beds, operating rooms and diagnostic services, are contingent on each Professional Staff Member providing his or her share of on call coverage for speciality services.

(b) If a Professional Staff Member wishes to withdraw, totally or partially, from the provision of on call coverage services, his or her access to Corporation resources will be reduced, in order to allow room for a replacement Professional Staff Member to join the Professional Staff and the coverage rota.

(c) Specialists who work primarily or exclusively in an ambulatory setting are not excused from the obligation to provide on call coverage, and such specialists will be part of the coverage rota for that speciality.

4.9 *Clinical Procedures:*

Each department, division, service or program shall make recommendations to the MAC regarding the clinical procedures to be performed in each department, division, service or program.

4.10 *Orientation for New Professional Staff Members*:

All new members and/or applicants for membership to the Professional Staff Member shall undergo an orientation, as required by the Medical By-Laws, including both a general orientation to the Hospital/Site and a more detailed orientation to the department, division, service or program concerned.

(a) The Designated Responsible Professional Staff Member and/or the Chief of Staff shall be responsible for organizing the orientation. The orientation should involve physicians, dentists and midwives, Hospital Management and/or other staff resources and should include both clinical and facility orientation.

Examples of areas that should be covered by the orientation are:

(i) Hospital mission and philosophy,

(ii) Hospital By-laws, Rules,

(iii) Departmental and Service Policies,

(iv) On call coverage requirements and procedures,

(v) Fire safety,

(vi) Disaster response plan,

(vii) Security and emergency numbers,

(viii) Medical staff facilities and room numbering systems,

(ix) Cardiac arrest procedures,

(x) Press releases and media contact,

(xi) Medical record policies, and

(xii) Confidentiality of patient information.

4.11 *Locum Tenens*:

(a) Every Professional Staff Member who wishes his/her Hospital practice covered by a locum tenens shall submit the request to the MAC at least 60 days in

advance, to allow sufficient time to have the locum tenens' credentials evaluated. In emergency situations the MAC may waive this time requirement.

(b) Completion of locum tenens medical records and charts shall be the responsibility of the Professional Staff Member whom the locum tenens has replaced or of the Most Responsible Professional Staff Member.

4.12 *Duty of Supervisors of Associate Staff Members*:

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

(i) observe the member's performance of procedures and practice in the Hospital;

(ii) review the member's charts and work in order to evaluate the competence of the Associate;

(iii) guide and advise the member on medical staff organization and procedures; and

(iv) encourage the appropriate use of Hospital/Site resources.

(b) A supervisor shall immediately inform the Chief of Staff, or Designated Responsible Professional Staff Member and the Chief Executive Officer of any evidence of incompetence on the part of the Associate.

4.13 *Report of Supervisors of Associate Staff Members*:

(a) During the probationary period, the Designated Responsible Professional Staff Member and the supervisor shall make written reports to the Chief of Staff, as required by the Medical By-Laws.

(b) The reports referred to in paragraph (a) shall include:

(i) comments on the knowledge and skill which has been shown by the Associate staff member;

(ii) the nature and quality of the Associate's work in the Hospital/Site, including:

(A) the number of patients treated and procedures carried out by the Associate;

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

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

(iv) comments on the utilization of Hospital/Site resources; and

(v) comments on the Associate staff member's ability to function in conjunction with other members of the Hospital/Site staff.

SECTION 5 – PROFESSIONAL STAFF ORGANIZATION

5.1 *Definition of Membership of Speciality Departments*:

The qualifications for membership shall be appropriate certification by the Royal College of Physicians and Surgeons of Canada, or the Royal College of Dental Surgeons of Ontario, or the College of Midwives, although physicians, dentists or midwives with appropriate training and experience acceptable to the department, may be members upon approval of the MAC.

5.2 *Practice Requirements*:

Practice requirements shall be established to maintain membership in a program, service, division or department. This may include such things as on-call, service to emergency, and time commitment to practice in the community being served.

5.3 *Practice Review and Evaluation*:

Practice review and evaluation shall include periodic peer evaluation of clinical practice and review of continuing medical education activities.

5.4 *Meetings*:

The Professional Staff Members in each department shall hold regular meetings as set out in the Medical By Laws. Minutes including a list of attendance shall be kept of each such meeting and shall be forwarded to the respective council(s), and to MAC as appropriate.

SECTION 6 – ISSUES MANAGEMENT

6.1 In the event that any situation arises at any Site with respect to any matter including, without limitation, quality of care, patient or staff complaints, on call participation, staff supervision, staff responsibility or discipline, the appropriate process shall be to immediately notify the Chief of Staff and Chief Executive Officer, who shall take any action he or she deems appropriate.

6.2 Upon being notified of a situation at a Hospital/Site, the Chief of Staff may, in his or her discretion, contact the relevant Designated Responsible Professional Staff Member(s), and/or Chief Executive Officer of the Corporation, as necessary or appropriate and shall, in any event, report to the Designated Responsible Professional Staff Member(s), or Chief Executive Officer of the Corporation with respect to any significant matters affecting any department, division, service, program or the Corporation as a whole.

II CLINICAL RULES

SECTION 1 – CONSULTATIONS

1.1 *Definition*:

(a) For the purpose of these rules, a consultant is defined as a Professional Staff Member who is qualified by both experience and training to give an opinion on the condition in question.

1.2 *Requirements*:

(a) In the following circumstances, the Most Responsible Professional Staff Member shall consult with one or more appropriate members of the Professional Staff regarding:

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

(ii) every patient where there is a failure to progress as expected under treatment;

(iii) every patient where a serious problem of diagnosis or management exists; and

(iv) all other cases in which the Service Councils require that a consultation be requested.

(b) Each Service Council shall develop policies, approved by the MAC, to cover consultations.

1.3 *Delegated Medical Acts*:

All "Delegated Medical Acts" to be performed in the Hospital/Site must be approved by the MAC and the Board and performed in accordance with the *Regulated Health Professions Act, 1991* (Ontario).

1.4 *Medical Responsibility During Transfer of Patients Between Hospitals/Sites*:

(a) Patients shall be transferred from the care of a Professional Staff Member at the sending Hospital/Site to the care of a Professional Staff Member at the receiving Hospital/Site.

(b) The sending Professional Staff Member should communicate directly with the receiving Professional Staff Member prior to transfer. Appropriate plans for medical care of the patient en route should be developed. These arrangements shall be documented on the patient's medical record.

(c) The OMA/OHA standardised Emergency Transfer Form or Routine Transfer Form should be used.

1.5 *Medication and Formulary System*:

(a) The Medical Advisory Committee shall prepare, maintain and update a Hospital/Site formulary after giving consideration to the recommendations of the committee responsible for pharmacy and therapeutics.

(b) The members of the Corporation staff shall acquaint themselves with and adhere to the rules regarding drug administration as stated in the Hospital's formulary.

(c) The following shall be incorporated into staff policies:

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

(ii) non-formulary drugs;

(iii) restricted/controlled drugs;

(iv) investigational drugs;

(v) medication orders, including standing orders and routines, range dosages and automatic stop orders;

(vi) self medication/bedside medication;

(vii) adverse drug reactions; and

(viii) medication incidents.

SECTION 3 – ADMISSION TO HOSPITAL

2.1 No Professional Staff Member shall order the admission of a person to the Hospital/Site unless, in the opinion of the Professional Staff Member, it is clinically necessary that the person be admitted.

SECTION 4 – STERILIZATION OF PERSONS UNDER SIXTEEN

3.1 No physician shall perform a surgical operation for the purpose of rendering a patient incapable of insemination or becoming pregnant where the patient is under the age of 16 years unless the physician is of the opinion that the surgical operation is medically necessary for the protection of the physical health of the patient.

SECTION 4 – ANAESTHESIA

4.1

(a) No general, spinal, epidural or intravenous anaesthetic or a regional nerve block (other than a mandibular nerve block for a dental procedure) shall be administered to a patient unless the following are entered in the medical record of the patient:

(i) a history of any present disability/disease (and any previous medical history relevant to the disability/disease);

(ii) the findings of a physical examination of the patient; and

(iii) the results of any other laboratory test considered necessary by the attending Professional Staff Member.

(b) No general, spinal, epidural or intravenous anaesthetic or a regional nerve block (other than a mandibular nerve block for a dental procedure) shall be administered to a patient unless an anaesthetist has:

(i) taken a medical history and made a physical examination of the patient sufficient to enable the anaesthetist to evaluate the condition of the patient and to choose a suitable anaesthetic; and

(ii) entered (or caused to be entered) and authenticated on the anaesthetic record the data (from the patient's history, laboratory findings and physical examination) relevant to administering the anaesthetic for the proposed procedure.

(c) Subsections (a) and (b) above do not apply where the anaesthetist and attending physician are jointly of the opinion that a delay for the purpose of compliance would endanger the life or a limb or vital organ of the patient.

(d) Where an anaesthetist intends to administer an anaesthetic referred to in subsections (a) and (b) above without complying with these two subsections, and the anaesthetist and attending physician are of the opinion that a delay for the purpose of compliance would endanger the life or a limb or vital organ of the patient, the anaesthetist and attending physician shall (as soon as possible) jointly prepare and authenticate a statement that sets out that opinion.

(e) Where an anaesthetic referred to in subsections (a) and (b) above is administered to a patient, the anaesthetist shall prepare an anaesthetic report that shows:

(i) the medications given to the patient in contemplation of anaesthesia;

(ii) the patient airway, circuit and monitors used on the patient;

(iii) the anaesthetic agents used (including the methods of administration of the agents and the proportions or concentrations of all agents) and administered by inhalation to the patient;

(iv) the names and quantities (including times administered) of all drugs given by injection to the patient;

(v) the duration of the anaesthesia on the patient;

(vi) the estimated fluid loss experienced by the patient;

(vii) the quantities and type of all blood products and other fluids administered intravenously to the patient during the procedure; and

(viii) the vital signs of the patient before, during and after anaesthesia.

(f) Every anaesthetist who administers an anaesthetic to a patient shall direct the post-anaesthetic care of the patient.

SECTION 5 – SURGERY

5.1 (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; and

(ii) enters (or causes to be entered) and authenticates the diagnosis and a statement of the findings on the physical examination in the patient's medical record.

(b) Every surgeon who performs an operation on a patient shall direct the post-operative care of the patient until responsibility for the care of the patient is assumed by another appropriate physician.

(c) Every anaesthetist who administers an anaesthetic to a patient shall direct the post-anaesthetic care of the patient.

(d) Where tissues are removed from a patient during an operation or curettage, the surgeon shall cause all tissues removed from the patient to be sent, together with a short history of the case and a statement of the findings of the operation, for laboratory examination/report.

(e) Notwithstanding subsection d) above, where the tissue removed is a haemorrhoid, lens, prepuce, tonsil, toenail or tooth, the tissue shall not be sent for laboratory examination/report unless so requested by the surgeon conducting the operation.

SECTION 6 – ESTABLISHMENT OF RULES

6.1 The MAC shall make recommendations to the Board on the establishment of department, division, service or program rules after giving consideration to the recommendations of the departments, divisions, services or programs affected.

6.2 The MAC shall make recommendations to the Board on the establishment of general rules after giving consideration to the recommendations of the medical staff.

6.3 The MAC shall make recommendations to the Board on amendments to the Rules and Regulations as may be necessary.

APPENDICES

Article I. APPENDIX "A"

Substitution for greater than 48 hours, pursuant to General Rules, Section 4.3 (e).

Article II. **1.** *Family Medicine Council:*

The following is the policy of the Family Medicine Council, which covers both the Department of Urban Family Medicine and Community Family Medicine.

(a) When substitution is to cover a period greater than 48 hours because of vacation or pre-determined extended leave, then the Most Responsible Physician shall designate the new Most Responsible Physician by transfer of care recorded in the patient record.

(b) When substitution is to cover a period greater than 48 hours when the Most Responsible Physician is not on vacation or pre-determined leave (i.e. weekend) then the responsibility for coverage of problems arising with that in-patient is with the "on-call physician" for the call group of that Most Responsible Physician. A formal transfer of care will not need to be recorded in the patient record.

(c) If the Most Responsible Physician is not affiliated with an "on-call" group and will not be available and accessible for a period greater than 48 hours, then that Most Responsible Physician shall designate the new Most Responsible Physician by transfer of care recorded in the patient record.

(d) If evaluation or service is required by an in-patient in the context of Policy #1, 2 or 3 and it is not possible to implement either of Policies #1, 2, or 3, then the responsible hospital nursing staff shall contact, in the following sequence dependent on availability, for assistance:

(i) Department Chief (or substitute)

(ii) Council Chair (or substitute)

(iii) Chief of Staff (or substitute)