

QUEEN ELIZABETH HOSPITAL MEDICAL STAFF RULES

Approved and Effective INSERT DATE

FINAL – June 12, 2014

TABLE OF CONTENTS

PART 1 – GENERAL PROVISIONS 4
1.0 Preamble 4
1.1 Definitions..... 4

PART 2 – MEDICAL ORGANIZATIONAL STRUCTURE OF Queen Elizabeth Hospital

2.0 Organizational Structure
2.1 Department and Program Meetings
2.2 Committees, General Information
2.3 QEH Local Medical Advisory Committee
2.4 QEH Local Medical Advisory Committee Executive Committee
2.5 Nominating Committee
2.6 QEH/HH Medical Staff Association Meetings
2.7 Medical Staff Dues
2.8 Attendance
2.9 Accountability to Clinical Department or Program Head
2.10 Appointment to the Medical Staff
2.11 Orientation and Activation of Clinical Privileges

PART 3 – Patient Care and Practitioner Related Provisions

Part A Patient Care

3.0. Preamble
3.1 Admission of Patients
3.2 Attendance upon Patients
3.3 Practitioner’s Orders
3.4 Informed Patient Consent
3.5. Leaving Against Medical Advice
3.6. Discharge Planning/Bed Management/Bed Utilization
3.7 Levels of Care Designation, Including “Do Not Resuscitate” Orders
3.8 Patient Death
3.9 Autopsies
3.10 Organ and Tissue Procurement
3.11 Quality Assurance and Risk Management

Part B Practitioner Related

3.12 On Call and Service Coverage
3.13 Patient Care Rounds
3.14 Supervision of Medical Students and Residents
3.15 Practitioner Supervised Health Professionals
3.16 Designation of Most Responsible Practitioner/Transfer of Responsibility
3.17 Absence from Clinical Practice, Retirement, Resignation
3.18 Governance of Professional Conduct and Medical Ethics
3.19 Research
3.20 Disruptive Behaviour in the Health Care Workplace

Part C – Documentation, Records and Record Keeping

- 3.21 Personal Directives**
- 3.22 Health Records**
 - 3.22.1 General Guidelines**
 - 3.22.2 Documentation Standards**
 - 3.22.2.1 Standards**
 - 3.22.2.2 Admission (History and Physical) Note**
 - 3.22.2.3 Progress Notes**
 - 3.22.2.4 Practitioner Orders**
 - 3.22.2.5 Operative/Procedure Reports**
 - 3.22.2.6 Anaesthesia Records**
 - 3.22.2.7 Consultation Reports**
 - 3.22.2.8 Transplantation**
 - 3.22.2.9 Surgical Pathology Reports**
 - 3.22.2.10 Discharge Summaries**
 - 3.22.2.11 Autopsy Reports**
 - 3.22.2.12 Emergency Department Notes and Ambulatory /Outpatient Reports**
 - 3.22.3 Health Record Completion Expectations (Summary)**
 - 3.22.4 Curtailment of Clinical Privileges for Incomplete Health Records**

Part D - Other

- 3.23 Disaster Planning/Emergency Preparedness**
- 3.24 Pharmacy**
- 3.25 Communicable Diseases**

- Appendix A – Template for the Development of Terms of Reference**
- Appendix B – Duty to Report Death to Coroner**
- Appendix C – Definitions from the HPEI Medical Staff Bylaws**

PART 1 – GENERAL PROVISIONS

1.0 PREAMBLE

- 1.0.1 The Queen Elizabeth Hospital (QEH) Medical Staff are governed by the Health PEI Medical Staff Bylaws and by the Queen Elizabeth Hospital Medical Staff Rules (the Rules).
- 1.0.2 The Rules govern the day to day management of QEH Medical Staff affairs, and nothing in them shall alter the intent and purpose of the Bylaws. They are intended to create an atmosphere and framework within which each member of the Medical Staff can act with a reasonable degree of freedom and confidence. They are also intended to ensure that good patient care prevails at all times.
- 1.0.3 Additional details and procedures for operations may be described in the policies of individual Departments or Programs and the terms of reference of committees established by the QEH Local Medical Advisory Committee (QEH LMAC) or by Departments/Programs. If there is a conflict between any provisions of these Rules and the rules or policies of a Department, Program or committee, the provisions of these Rules shall prevail.
- 1.0.4 Initial adoption of, or changes to the Rules shall require the approval of the QEH LMAC and a two-thirds majority vote of active and associate staff members present at a general QEH/Hillsborough Hospital Medical Staff Association meeting, prior to approval by the Provincial Medical Advisory Committee (PMAC) and the Health PEI Board.
- 1.0.5 Initial adoption of, or changes to departmental or program rules requires a majority vote at a regularly scheduled departmental or program meeting, and by the QEH Local Medical Advisory Committee.
- 1.0.6 Notice of amendments to the Rules, or the adoption of new Rules shall be given at least 10 days before the date set for the meeting at which they shall be presented.
- 1.0.7 Practitioners are responsible to review and remain informed regarding new or revised Bylaws, Rules and Policies which are applicable to, or of importance to, the QEH Medical Staff. Notification of new and revised Bylaws, Rules and Policies is the responsibility of the Executive Director of Medical Affairs (Bylaws and provincial rules and policies) and the QEH Medical Director (QEH Rules and policies). QEH Rules and Policies will be posted on the QEH Medical Staff Rules and Policies section of the HPEI internal information website <http://iis.peigov/dept/health/index.html> .

Health PEI policies are posted on the HPEI internal policy website <http://iis.peigov/dept/health/manual/index.html>).
- 1.0.8 Medical Staff with questions or comments regarding the Bylaws, Rules and/or policies may bring them to the attention of their Department or Program Head or to the Medical Director.

1.1 DEFINITIONS

Unless otherwise provided herein, all defined terms have the same meaning as that ascribed to them in the Definitions section of the Bylaws. Definitions as found in the Bylaws are attached as a

Appendix C and are subject to any amendments to the Bylaws. They are provided solely for the convenience of the reader.

1.1 Additional Definitions as found in these Rules:

Medical Director	A Practitioner designated by the Executive Director of Medical Affairs as the most senior medical administrative leader at the QEH.
Impact Analysis	An assessment that estimates the effect on available resources of a change or proposed change in the Physician Resource Plan or an individual Practitioner’s Clinical Privileges, or a new Procedure or new Program or Professional Service, and identifies any new resources required to effect the proposed change.
Legal Representative	Person(s) other than the Patient who are legally authorized to make decisions in partnership with, or in substitution for, the Patient as described in Health PEI or QEH consent policy and procedures, and pursuant to relevant legislation including, but not limited to, the <i>Consent to Treatment and Health Care Directives Act (PEI)</i> and the <i>Mental Health Act (PEI)</i> .
Medical Student	A student on the Medical Education Register of the College of Physicians and Surgeons of PEI and registered in an approved undergraduate medical training program.
Most Responsible Practitioner	The single, designated Practitioner who carries the primary responsibility for the care of a Patient within the QEH.
Practitioner-supervised Health	A health professional employed or contracted by Health PEI who provides Health PEI approved Professional Patient care and clinical services as delegated by, and as a designate of, a supervising, or in the case of a Nurse Practitioner, a collaborating Practitioner(s). Practitioner- supervised Health Professionals include, but are not limited to, clinical and surgical assistants, clinical associates, physician extenders, physician assistants and nurse practitioners.
Personal Directive	A directive of a Patient related to health care under the <i>Consent to Treatment and Health Care Directives Act (PEI)</i>
Resident	A Physician trainee on the Medical Education Register of the College of Physicians and Surgeons of PEI in an approved postgraduate training program.

1.2 Where the contents so require, words importing the singular number shall include the plural and vice versa, and words importing persons shall include corporations and vice versa.

PART 2 – MEDICAL ORGANIZATIONAL STRUCTURE

2.0 ORGANIZATIONAL STRUCTURE

- 2.0.1 The organizational structure of the QEH Medical Staff includes, but is not limited to:
- a. Medical administrative leadership positions: Medical Director, Department Heads, Program Heads, Division Heads, and other physician leads as appointed from time to time .
 - b. The QEH LMAC and Standing Committees of the LMAC, as established pursuant to sections 18- 21 of the Bylaws. The Standing Committees include but are not limited to:
 - Endoscopy
 - Infection Prevention and Control
 - Intensive Care/Coronary Care
 - Medical Equipment Priorities
 - Medical Staff Executive
 - Medication Management
 - Nominating
 - Operating Room
 - Perinatal
 - Resuscitation
 - c. Clinical Departments as established pursuant to Sections 10 and 11 of the Bylaws, their sub-component Divisions, and their committees. The Departments and Divisions include but are not limited to:
 - Anaesthesia
 - Emergency Medicine
 - Family Practice
 - Hospitalist Medicine
 - Internal Medicine
 - Obstetrics and Gynecology
 - Pediatrics and Newborn Medicine
 - Physical Medicine and Rehabilitation
 - Surgery, which shall include surgical subspecialties, dental and oral maxillofacial surgery.
 - d. Provincial programs as established pursuant to sections 10 and 11 of the Bylaws, their sub-component Divisions, and their committees. The Programs include but are not limited to:
 - Laboratory Medicine
 - Divisions of Medical Microbiology, Clinical Biochemistry, PEI Transfusion Service, Hematology and Anatomical Pathology
 - Diagnostic Imaging
 - Mental Health and Addictions
- 2.0.2 These groups shall be subject to the collective responsibilities identified in the Bylaws and these Rules, and the appointed leaders of these groups will be responsible for ensuring that these responsibilities are carried out.
- 2.0.3 The appointment and accountability, responsibilities and duties of the Medical Director, Department and Program Heads and Division Heads are found in sections 11 and 12 of the Bylaws and in the positional job descriptions.

QUEEN ELIZABETH HOSPITAL MEDICAL STAFF RULES

- 2.0.4 A Department Head shall have the authority and the responsibility for the supervision over any matter affecting the admission, treatment and discharge of any patient within his/her Department.
- 2.0.5 The Heads of the Departments of Surgery and Anaesthesia shall be responsible to ascertain that all dental patients requiring Anaesthesia have proper pre-and post-operative care including pre- operative history and physical examination.
- 2.0.6 When a department head is of the opinion that a serious problem exists in the diagnosis and care of an inpatient or an outpatient within his or her department, he or she shall immediately discuss the condition, diagnosis, care and treatment of the patient with the attending Medical Staff, and, if changes in diagnosis, care or treatment satisfactory to the department head are not promptly made, he or she shall follow the applicable procedures outline in Section 77 of the Bylaws (Immediate Suspension of Privileges).
- 2.0.7 Where the department head is unable to discuss such concerns with the attending Medical Staff in a timely fashion, the department head shall carry out his or her duties as prescribed in Section 77 of the Bylaws as if he had held the discussion with the Medical Staff.
- 2.0.8 Where the matter involves more than one (1) clinical department, the heads of the departments shall act in concert.

2.1 DEPARTMENT AND PROGRAM MEETINGS

- 2.1.1 Departments and Programs shall meet at least 10 times per year.
- 2.1.2 The purpose of these meetings shall be to:
 - a. review the clinical work, operation and functioning of the department;
 - b. to conduct regular morbidity and mortality rounds and/or other quality improvement activities;
 - c. to facilitate interdisciplinary cooperation;
 - d. to facilitate manpower planning for the Department;
 - e. in cooperation with the relevant administrative manager(s), to develop recommendations for equipment acquisition to the Medical Equipment Priorities Committee.
- 2.1.3 Meetings shall be chaired by the Department or Program Head or Designate. Minutes shall be kept and a copy shall be forwarded to the office of the Medical Director.

2.2 COMMITTEES

- 2.2.1. Committees of the Medical Staff may be standing or ad hoc and are established pursuant to Section 21 of the Bylaws. Committees may be composed of physicians and non-physician members of HPEI staff, as well as lay members of the public, when appropriate.
- 2.2.2 The QEH Medical Staff has a duty to participate on committees when requested.

2.2.3 TERMS OF REFERENCE

- a. Upon appointment, each committee shall develop such terms of reference as required for its effective functioning, consistent with the provisions of the Bylaws and these Rules. Terms of reference shall

include but are not limited to: purpose, composition including alternative members if any, term of committee appointment (if any), duties and responsibilities, decision-making processes, and reporting and notification requirements. A template for the development of terms of reference is included as Appendix A. Terms of reference shall be approved by QEH LMAC.

- b. Terms of reference for each standing committee shall be reviewed annually and approved by the QEH LMAC.
- c. The terms of reference for each ad hoc committee shall be defined at the time of appointment. Such a committee will cease to exist upon completion of its special task.

2.2.4 MEETING FREQUENCY

Each standing committee shall meet at least 10 times per year at the call of the chair, unless otherwise set forth in the committee's terms of reference, the Bylaws or these Rules.

2.2.5 COMMITTEE CONDUCT

- a. All committee members shall:
 - I. display ethical and business-like conduct;
 - II. avoid and declare conflicts of interest, and maintain the confidentiality of the committee's business as necessary for its effective functioning;
 - III. participate constructively in committee activities and assist with the efforts of the committee to fulfill its mandate and achieve its objectives;
 - IV. treat other committee members and staff with respect;
 - V. attend meetings on a regular and punctual basis.
- b. The Chief Administrative Officer of the QEH, the Medical Director and the President of the Medical Staff shall, unless otherwise specified, be ex-officio, non-voting members of all committees specified in these Rules.
- c. Unless otherwise specified by the Committee, meetings shall be guided by Robert's Rules of Conduct.

2.2.6 REMOVAL

If a member of a committee ceases to be a member of the Medical Staff, fails to discharge his/her responsibilities as a committee member pursuant to section 2.2.4 of these Rules, or if other reasonable grounds exist, that member may be removed by the Medical Director upon the recommendation of the Committee Chair.

2.2.7 VACANCIES

- a. Physician members of all standing and ad hoc committees shall be appointed from the Active and Associate Medical Staff by the LMAC annually and when any vacancy occurs. Except where otherwise provided for in the Bylaws or the Rules, the Chair of such committees shall be recommended by the Nominating Committee for election at the Annual Meeting of the Medical Staff Association. There shall be no ceiling on successive annual membership on committees.
- b. Except where otherwise provided for in the Bylaws or the Rules, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made

until the completion of that member's term;

- c. In an exceptional circumstance, the LMAC may appoint an interim replacement member to fulfill a member's committee term until the vacancy can be filled in the same manner in which an original appointment to such committee was made.

2.2.8 QUORUM AND MANNER OF ACTION

- a. Except as otherwise specified in the Bylaws, these Rules, or the Committee terms of reference, the quorum for a committee shall be fifty percent plus one of the members entitled to be present and vote.
- b. Except as otherwise specified in the Bylaws or these Rules, the actions of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the committee. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, provided any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by the Bylaws and these Rules.
- d. Except where otherwise provided for in the Bylaws and these Rules, committee meetings may be conducted in-person, by teleconference, by webex conference, or videoconference. Committee actions arising from a meeting, such as a recorded vote, may be conducted in-person, by e-mail or other electronic means, teleconference, webex conference or videoconference.

2.2.9 MINUTES

Minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken/agreement on matters (where recording is required). A copy of the minutes shall be signed by the committee chair of the meeting and forwarded to the Medical Director's Office.

2.2.9.1 REPORTING

- a. All standing committees of the QEH LMAC shall report annually to the QEH LMAC and the QEH/HH Medical Staff Association.
- b. Each ad hoc committee shall report periodically as requested to the LMAC and upon the conclusion of its special task.

2.3 QEH LOCAL MEDICAL ADVISORY COMMITTEE

2.3.1 ESTABLISHMENT

The QEH LMAC is established pursuant to Sections 18 - 21 of the Bylaws.

2.3.2 COMPOSITION

The QEH LMAC Committee shall be composed of the following persons:

- a. All QEH Department Heads and Provincial Program Heads (or Program Head designate);
- b. Division heads as approved by LMAC;
- c. Chair of ICU/CCU Committee;

- d. Medical Director of Mental Health and Addictions;
- e. The President, QEH/HH Medical Staff Association
- f. The Vice President, QEH/HH Medical Staff Association
- g. The Secretary-Treasurer, QEH/HH Medical Staff Association
- h. Chief Administrative Officer, QEH;
- i. Director of Nursing, QEH
- j. QEH Medical Director, QEH (Chair)

2.3.3 VOTING MEMBERS

The following members shall attend and vote on all issues for discussion at QEH LMAC meetings:

- a. the Chair, who shall only vote in the event of a tie
- b. the Department Heads, Program Heads (or designate)
- c. the Medical Director, Mental Health and Addictions (or designate)
- d. the Chair, ICU/CCU Committee
- e. the President, Vice President and Secretary-Treasurer of the QEH/HH Medical Staff Association

2.3.4 EX-OFFICIO NON-VOTING MEMBERS

The following shall attend all meetings of the QEH LMAC but may not vote:

- a. the Chief Administrative Officer, QEH
- b. the Director of Nursing, QEH

2.3.5 DUTIES AND RESPONSIBILITIES:

- A. The QEH LMAC shall consider, advise and report to the Provincial Medical Advisory Committee and the Executive Director of Medical Affairs on all matters pertinent to patient care and to the Medical Staff, as established in the Bylaws. The responsibilities include but are not limited to:
 - a. working with the PMAC to assure that medical staff services demonstrate quality, safety, coordination, timeliness and adequacy
 - b. advising the Medical Director on matters related to Medical Staff and on other issues as requested;
 - c. considering, acting on or referring to the PMAC items which are submitted by an Executive Director of HPEI
 - d. reporting to the Executive Director through the Chair
 - e. other duties as assigned by the PMAC
- B. Additional duties and functions of the QEH LMAC shall be to:
 - a. act on behalf of the Medical Staff, as well as to coordinate the activities and general policies of the various departments and services subject to such limitations as may be imposed by the Committee by the Bylaws or Rules;
 - b. make recommendations to the PMAC concerning:
 - i. applications for appointment or reappointment to the QEH Medical Staff;
 - ii. the Hospital privileges to be granted to each member of the QEH Medical Staff;
 - iii. the quality of medical care provided in the Hospital;
 - iv. Bylaws respecting the HPEI Medical Staff;

- v. Rules respecting the QEH Medical Staff;
- vi. provide supervision in general of the practice of medicine in the Hospital;
- vii. receive and act upon the reports of the QEH Medical Staff Committees
- viii. consider and recommend action to the Chief Administrative Officer of the QEH on matters of a medico-administrative nature;
- ix. assist in ensuring ethical professional conduct on the part of all members of the Medical Staff and initiate such prescribed corrective matters as are indicated;
- x. assist in ensuring that there is continuing clinical appraisal and quality improvement activity by departments, or by committees, with regular reports and recommendations in order to maintain a high quality of professional service and continuing education.

2.4 QEH LOCAL MEDICAL ADVISORY COMMITTEE EXECUTIVE COMMITTEE

2.4.1 ESTABLISHMENT

The QEH LMAC Executive Committee is established pursuant to Article 21 of the Bylaws.

2.4.2 COMPOSITION

2.4.2.1

- A. The QEH LMAC Executive Committee shall be composed of the following voting members:
 - a. President, QEH/HH Medical Staff Association;
 - b. Vice President, QEH/HH Medical Staff Association;
 - c. One representative from medical departments and programs (Anaesthesia, Diagnostic Imaging, Laboratory Medicine, Internal Medicine, Pediatrics, Physical Medicine and Rehabilitation)
 - d. One representative from surgical departments (Obstetrics and Gynecology, Surgery)
 - e. One representative from Family Practice, Hospitalist Medicine and Emergency Department.
- B. The QEH LMAC Executive Committee shall be composed of the following non-voting members:
 - a. Executive Director, QEH
 - b. Director of Nursing, QEH

2.4.2.2 The term of voting members will be 3 years, or as appropriately adjusted to reflect term on LMAC.

2.4.3 DUTIES AND RESPONSIBILITIES

- a. The LMAC Executive Committee shall consider, advise and report to the QEH LMAC on matters referred to it from QEH LMAC with respect to issues affecting patient care or the effective functioning of the QEH Medical Staff.
- b. Upon request of the QEH LMAC, the LMAC Executive Committee shall develop and recommend policies on matters referred to it from the QEH LMAC, conjointly with Hospital Administration, the QEH/HH Medical Staff Association.

- c. The LMAC Executive Committee shall advise the QEH Medical Director on selected issues related to patient care, medical staff performance and function.

2.4.4 REPORTING AND AUTHORITY

2.4.4.1 The QEH LMAC Executive Committee reports to the QEH LMAC.

2.4.4.2 The QEH LMAC Executive Committee has no independent decision making authority.

2.4.5 MEETING FREQUENCY

Meetings of the QEH LMAC Executive Committee shall be at the call of the Chair or upon request of the QEH LMAC.

2.5 NOMINATING COMMITTEE

2.5.1 ESTABLISHMENT

The Nominating Committee is established pursuant to Article 21 of the Bylaws.

2.5.2 COMPOSITION

The Nominating Committee shall consist of the three (3) most immediate past Presidents of the QEH/HH Medical Staff Association who are available to sit on the Committee.

2.5.3 RESPONSIBILITIES AND DUTIES

- a. The Nominating Committee shall be responsible for preparing a list of nominations for the positions of executive officers, the chairs of all standing committees, the Heads of Departments and the Medical Advisory Committee representatives (other than the ex-officio members) for submission to the annual QEH/HH Medical Staff Association meeting. The report of the Nominating Committee shall not preclude nominations from the floor at the annual meeting.
- b. The report of the Nominating Committee shall be posted prominently at the Hospital at least ten (10) days prior to the annual meeting of the QEH/HH Medical Staff Association.

2.6 MEDICAL STAFF ASSOCIATION MEETINGS

- a. The QEH/HH Medical Staff Association is established pursuant to sections 22 – 24 of the Bylaws.
- b. The quorum shall be 25 members of the active and associate QEH/HH staff and Queen's County Community Medical Staff with privileges at the QEH/HH.

2.7 MEDICAL STAFF DUES

All members of the Active and Associate Medical Staff shall pay annual dues, the rates of which shall be established at a quarterly or annual meeting of the QEH/HH Medical Staff Association. Members with Active or Associate privileges at more than one HPEI acute care facility shall only be charged annual dues at the facility at which they are primarily based.

2.8 ATTENDANCE

- 2.8.1 All active and associate staff are required to attend at least 70% of the meetings of their Departmental/Program meetings.
- 2.8.2 All members of the LMAC are expected to attend at least 70% of LMAC meetings, as outlined in the Bylaws.
- 2.8.3 Absence at Departmental/Program, QEH/HH Medical Staff Association, or committee meetings may be excused at the discretion of the appropriate Chair in the case of:
 - a. Meetings or educational conferences elsewhere
 - b. Emergency
 - c. Illness
 - d. Family illness
 - e. Vacation
 - f. Emergency duty or on call duty
 - g. Pre-assigned operating room/outpatient clinic slates
- 2.8.4 If the attendance of any member of the QEH Medical Staff is below standards, written reasons may be required by the LMAC. The LMAC may, at its discretion:
 - a. Initiate a complaint against the physician following procedures established in the Bylaws.
 - b. Cause the Department Head, Program Director or Medical Director to place an attendance letter in the physician's file for review at the time of reappointment.
 - c. Excuse the member.

2.9 ACCOUNTABILITY TO CLINICAL DEPARTMENT OR PROGRAM HEAD

- 2.9.1 Each Practitioner is accountable to their Clinical Department Head(s) in the first instance for the responsibilities and obligations contained in the Bylaws and these Rules.
- 2.9.2 Procedural Privileges
 - I. Each Clinical Department shall develop a list of Procedures for Clinical Privileges with input from its members and through a process determined by each Clinical Department.
 - II. This list shall be reviewed by the Clinical Department at a minimum of every three years.
 - III. The list of Procedures for Clinical Privileges shall include the core procedures expected of Clinical Department members with Canadian residency training, and those which require extra training and supervision beyond that normally expected in a Canadian residency training program; those procedures which are resource intensive; and those Procedures whose utilization needs to be monitored for quality control and Patient safety reasons.
 - IV. Each list of Procedures for Clinical Privileges for a Clinical Department shall be reviewed by the QEH Local Medical Advisory Committee for consistency with provisions of the Bylaws and Rules and between Clinical Departments. The Local Medical Advisory Committee may make such changes as it may determine.
 - VI. The Local Medical Advisory Committee shall submit its lists of Procedures for Clinical Privileges for its Clinical Departments to the Provincial Medical Advisory Committee. The Committee shall review all submissions to ensure consistency within and between Hospitals and for consistency with provisions of the Bylaws.
- 2.9.3 Process to Add Procedures New to the QEH:
 - I. From time to time, new technologies and procedures will become available. It is the responsibility of each Clinical Department or Program to submit proposed Procedures new to the QEH to the LMAC.

Input is required from its members through a process determined by each Clinical Department or Program. In the case of resource intensive procedures, input will also be sought from the applicable QEH and/or HPEI health technology assessment and product evaluation portfolios in the form of an Impact Analysis.

- II. The proposal shall include an assessment of the need for the proposed Procedure, the ability of the QEH/HPEI to support the Procedure, and the proposed credentialing criteria.
- III. The requests, together with any necessary impact analyses and recommendations from other relevant bodies (e.g. health technology assessment or product evaluation portfolios) shall be submitted to the LMAC for approval. However, for those procedures requiring significant resource expenditure, LMAC shall make a recommendation for introduction of the new Procedure within the QEH to the QEH Senior Leadership Team. Final approval for those requests by the Chief Administrative Officer of the QEH is required.

2.10 APPOINTMENT TO THE MEDICAL STAFF

Application, appointment and reappointment to the Health PEI Medical Staff shall follow the processes established in Parts III, IV and V of the Bylaws.

2.11 ORIENTATION AND ACTIVATION OF CLINICAL PRIVILEGES

- a. Activation and maintenance of clinical privileges requires the successful completion of:
 - I. IT systems training
 - II. Privacy protection education
 - III. Occupational Health and Safety assessments (reference Immunization and Tuberculosis Testing Policy 1-20-90-70)
It is required that IT systems training be conducted prior to the activation of clinical privileges. Privacy protection education and completion of Occupational Health and Safety assessments may be conducted concurrently with activation of clinical privileges in circumstances where prior arrangements cannot be made.
- b. Each new member of the Medical Staff shall be oriented to QEH/HPEI processes and their site(s) of clinical activity. This is a joint responsibility of each new Practitioner, HPEI and the relevant clinical Department or Program Head and Site Medical Director(s). The Clinical Department Head shall be responsible for the new member's orientation to the functions, expectations, and rules and regulations of the Clinical Department/Program and to identify a mentor for the new member. The QEH Medical Director shall be responsible for the new member's general orientation to the QEH and relevant QEH/HPEI policies and procedures, rules and regulations.
- c. This orientation will vary depending on the Practitioner's prior association with and knowledge of HPEI and the site(s) of clinical activity and should occur upon activation of clinical privileges or as soon as is practical thereafter. An abbreviated orientation may be appropriate for short term locum tenens. In general, the orientation should ensure that the Practitioner has been:
 - I. given access to a copy of the Bylaws and these Rules of the Medical Staff, the QEH Medical Staff orientation package, and relevant QEH/HPEI policies and procedures, and has had an opportunity to review them;
 - II. oriented to the reporting relationships pertinent to their appointment both within and external to their Clinical Department(s);
 - III. provided with a mentor within the same Clinical Department or Program;

- IV. oriented to the physical plan of the relevant site(s) of clinical activity and the range of programs and professional services offered in the site(s) of clinical activity.
 - V. oriented to Health Records and requirements for recorded care; and,
 - VI. oriented to the ambience, philosophy, and general operating procedures of the relevant site(s) of clinical activity.
- d) The orientation will be provided by one or more of:
- I. Clinical Department or Program Head or designate(s);
 - II. The Site Medical Director(s) or designate(s);
 - III. QEH/HPEI operational staff.
- e) A checklist of items reviewed will be completed during the orientation and placed in the Practitioner's file.

PART 3 PATIENT CARE AND PRACTITIONER RELATED PROVISIONS

3.0 A. PATIENT CARE

This section of the Rules describes patient care and Practitioner-related provisions. Each Practitioner shall also be governed by relevant QEH/HPEI policies and procedures.

3.1 ADMISSION OF PATIENTS

3.1.1 Every patient in the Hospital shall be in the care of a member of the QEH Medical Staff with the appropriate clinical privileges and who shall be responsible for the overall care of the patient.

3.1.2 A Patient whose clinical condition warrants admission shall be admitted by a Practitioner with appropriate Clinical Privileges. The practitioner entering the order to admit the Patient is known as the Admitting Physician.

3.1.3 Every Patient admitted to the hospital, or who receives emergent, urgent or elective evaluation or treatment on an ambulatory or "Day Procedure" basis, shall have an identified Most Responsible Practitioner. The identity of the Most Responsible Practitioner shall be documented in the Patient's health record at the time of admission and the Patient shall be informed of his/her name by the Practitioner, his/her designate, or the nursing staff responsible for the Patient's care. The Most Responsible Practitioner has the duty, responsibility and authority to direct all medical care for that Patient while in the hospital, and to make reasonable efforts to ensure continuity of care following discharge (see further section 3.16).

3.1.4 All Patients admitted to the Hospital require a provisional diagnosis, and shall be categorized by the Most Responsible Practitioner as emergent, urgent or elective. These categories are defined as follows:

- a. Emergent – acute injury or illness requiring immediate admission.
- b. Urgent – long delay in admission and treatment will endanger the life of the patient or result in major complications
- c. Elective - The Patient's condition warrants admission when accommodation in the Hospital is available (time is not the determining factor in the care and treatment of the Patient).

- 3.1.5 A Practitioner who wishes to admit an elective patient shall book these admissions according to established admitting procedures.
- 3.1.6 A Patient requiring emergent admission shall be:
- a. assigned to the Practitioner requesting or accepting the admission and care of the Patient;
or
 - b. assigned temporarily to an emergency department Physician who may:
 - I. admit the patient and remain the Most Responsible Practitioner, provided that he/she has appropriate Clinical Privileges;
 - II. admit as above, then transfer care to another Practitioner pursuant to section 3.15.2 of these Rules, provided that the receiving Practitioner is available and accepts the admission and care of the Patient (this should include a personal conversation with the receiving Practitioner); or
 - III. refer the Patient prior to admission to another Practitioner who has appropriate Clinical Privileges to admit and care for the patient (this should include a personal conversation with the potential receiving Practitioner);
- 3.1.7 The Most Responsible Practitioner shall indicate to the staff caring for the Patient, and in the Patient's health record, that he/she is the Most Responsible Practitioner.
- 3.1.8 No Patient shall be admitted to a Practitioner without that Practitioner's agreement. If an appropriate Practitioner willing and able to accept the admission and care of the Patient cannot be identified by the time of accommodation in the Hospital or is not available, the relevant Clinical Department Head or designate shall assign a Most Responsible Practitioner.
- 3.1.9 The Most Responsible Practitioner and any other Practitioner providing care to the patient shall provide sufficient information to staff as may be necessary to ensure protection of other Patients or Hospital staff, or to ensure protection of the admitted Patient from self-harm.

3.2 ATTENDANCE UPON PATIENTS

- 3.2.1 Each Patient shall receive timely and professional care appropriate to his/her condition. The frequency of attendance will be determined having regard to the condition of the Patient, these Rules and Provincial Rules.
- 3.2.2 Each Patient, except those specified below, shall be attended at least daily by the Most Responsible Practitioner or designate. A Patient designated Alternate Level of Care (ALC), excluding patients designated ALC-Long Term Care) shall be visited at least 3 times per week. A Patient designated ALC-Long Term Care who is awaiting placement in a long term care facility shall be visited at least once per week.
- 3.2.3 Upon being notified that a patient's condition is deteriorating, the MRP shall attend the patient promptly and shall work to stabilize the patient and provide urgent care as required and consistent with the level of resources available. This may be in collaboration with a consultant physician or physicians as necessary.

3.3 PRACTITIONER'S ORDERS

- 3.3.1 Medication and treatment orders shall be in compliance with applicable QEH/HPEI policies and procedures (e.g. Order Management for Patient Care – CPOE Environment).
- 3.3.2 All orders shall be either written in the Patient's health record or entered directly into the Patient's electronic health record (if applicable). If orders are in writing, they shall be written using blue or black ink, on the appropriate form and shall be legible, complete, dated, timed and signed by the Most Responsible Practitioner or designate. A ballpoint or similar pen shall be used where multiple copies are expected. Date format shall be YYYY/MMM/DD (Chart Documentation Standard 1.0-90-62-30).
- 3.3.3 It shall be the duty of the Most Responsible Practitioner to review the orders for their Patients on a regular basis.
- 3.3.4 A consulting Practitioner (or designated Medical Student or Resident) may write orders if he/she has appropriate Clinical Privileges and has been asked to participate in the Patient's care.
- 3.3.5 Orders that are written on the appropriate form by consulting Practitioners shall be executed, unless cancelled by the Most Responsible Practitioner or designate. Consulting Practitioners may elect to leave suggestions for orders. In this case, the orders will not be executed until ordered or countersigned by the Most Responsible Practitioner or designate.
- 3.3.6 Requests for consultations shall be in writing on the appropriate consultation request form or shall be entered directly into the Patient's electronic health record (if applicable), and shall include the reason for consultation, a brief history, and specific timelines in which the consultation is to be provided (based upon the nature of the Patient's condition and circumstances). Direct Practitioner to Practitioner discussion shall occur in urgent cases, and is preferable in all cases.

3.4 INFORMED PATIENT CONSENT

- 3.4.1 Practitioners shall be governed by the QEH/HPEI consent policy and procedures, as well as by relevant Legislation including, but not limited to, the *Consent to Treatment and Health Care Directives Act* (PEI), the *Adult Protection Act* (PEI) and the *Mental Health Act* (PEI).
- 3.4.2 Observation, assessment, examination, treatment, detention and control of persons admitted through an admission certificate shall be as set out in the terms of the *Mental Health Act*.

3.5 LEAVING AGAINST MEDICAL ADVICE

If a competent Patient leaves the QEH without the prior order or authorization of the Most Responsible Practitioner or designate:

- a. Written acknowledgment by the Patient and/or his/her Legal Representative that the patient is leaving against advice shall be requested when possible, and
- b. The Most Responsible Practitioner or designate shall make a notation on the Patient's health record that the Patient has left the Facility against the Practitioner's advice.

3.6 DISCHARGE PLANNING/BED MANAGEMENT/BED UTILIZATION

- 3.6.1 Practitioners shall work together, and with QEH/HPEI staff, administrative leaders and Medical administrative leaders, to ensure that inpatient beds are managed in an effective and efficient manner within, and across, all HPEI facilities. Bed utilization and management should ensure that:
- a. Patient access to Facilities is granted on the basis of need;
 - b. Patients are treated in the most appropriate Facility to meet their particular needs;
 - c. Standards of Patient care are continually evaluated to improve the quality of Patient care and optimize Patient lengths of stay; and
 - d. Patients are discharged from Facilities, including emergency departments and other acute care treatment areas, in an appropriate and timely manner.
- 3.6.2 Patient discharge planning shall commence at the time of admission to the QEH. Where possible, for elective admissions or inter-Facility transfers, discharge plans and arrangements should be made prior to admission. It is the responsibility of the Most Responsible Practitioner, and consulting Practitioners (if appropriate) to anticipate and begin early planning for discharge with QEH/HPEI staff, including nursing, home care, social services and other relevant health care professionals. Discharge planning must involve the Patient and the Patient's family as well as early consultation with receiving Facilities (if the patient is expected to require transfer to another Facility) and/or the personal or referring Practitioner. It also includes timely transmission of sufficient Patient information to facilitate safe and responsible care after discharge.
- 3.6.3 The Patient shall be discharged only on the order of the Most Responsible Practitioner or designate.
- 3.6.4 Most Responsible Practitioners are required to discharge Patients according to policy set by HPEI, the Local Medical Administrative Committee, the Provincial Medical Advisory and/or the QEH. Wherever feasible, discharge orders shall be written the day before discharge in order to facilitate the process of discharging a Patient. In this instance, the patient will be discharged by the care team unless his/her medical status declines.
- 3.6.5 The QEH Medical Director and the Chief Administrative Officer of the QEH shall be responsible for overseeing the effective utilization of Hospital beds with the exclusion of the acute psychiatric unit (Unit 9), which is the responsibility of the Medical Director of Mental Health and Addictions and the Director of Mental Health and Addictions. With Practitioner input, they shall develop mechanisms to:
- a. Allocate Facility beds on the basis of need;
 - b. Review health records to assess the appropriateness of admissions as well as the ongoing effectiveness and progress of discharge planning;
 - c. Oversee the implementation of any recommended changes to current bed utilization policies or processes.

3.7 LEVELS OF CARE DESIGNATION (INCLUDING "DO NOT RESUSCITATE" ORDERS)

- 3.7.1 Each Practitioner shall be governed by applicable QEH/HPEI policy and procedure.
- 3.7.2 The Most Responsible Practitioner will confirm in writing (or electronically if applicable) on the Patient's record that he/she has discussed with the Patient and/or his/her Legal Representative his/her diagnosis, prognosis, and the Patient's decision with respect to future treatment, including possible levels of care and resuscitation. Prior direction from a Patient and/or his/her Legal

Representative must be suspended immediately upon the subsequent request of the Patient and/or his/her Legal Representative.

- 3.7.3 The Most Responsible Practitioner will take into account, as appropriate: relevant instructions in a personal directive; instructions of his/her Legal Representative; and the best interests of the patient. Communication entered into the Patient's health record will be used to inform other health care personnel involved in the care of the Patient as to the basis and the rationale of decisions.
- 3.7.4 An order designating the Patient's level of care shall be recorded in the Patient's health record. If the Patient is admitted after hours, a verbal or telephone order will be accepted but the order shall be countersigned by the Most Responsible Practitioner within twenty-four hours. In the absence of such an order, Practitioners and other health care professionals providing care during an emergency or cardiopulmonary arrest shall assume that the highest level of care designation is in effect.

3.8 PATIENT DEATH

- 3.8.1 Pronouncement of death must be made by a Physician or designate.
- 3.8.2 As soon as is practical following the death of a Patient, the Most Responsible Practitioner or designate will notify the next of kin, determine whether the Coroner should be notified, determine whether organ/tissue donation is to be undertaken and whether an autopsy is to be requested and performed.
- 3.8.3 The Coroner shall be notified in all circumstances required by the *Coroner's Act* (PEI). These circumstances are attached as Appendix B.
- 3.8.4 The Most Responsible Practitioner or designate must complete a death certificate within forty-eight hours, unless directed otherwise by the Coroner.

3.9 AUTOPSIES

- 3.9.1 The autopsy is an important quality assurance measure and it is recommended that an autopsy be conducted in all instances where it is desirable to understand the deceased's condition at death. Indications for autopsy may include but are not limited to:
- a. evaluating clinical diagnostic accuracy, identifying previously undetected disease and/or contributory conditions.
 - b. death in which the family expresses concern or requires reassurance.
 - c. Death in which there is a significant question concerning effectiveness of therapy/extent of disease.
 - d. Death with known or suspected congenital malformation, disease or syndrome or undefined metabolic disease.
 - e. Cancer patients in whom there is no prior tissue diagnosis or site of origin of primary tumour is unknown.
 - f. Patients dying of internal bleeding – source unknown.
 - g. Patients with infections of undetermined type and/or source.
 - h. Fetal and unexpected pediatric deaths.

- i. Death in which it is believed that an autopsy would disclose known or suspected illness which may have a bearing on survivors.
- j. Patients who have participated in clinical trials approved by HPEI.

3.9.2 In addition:

- a. No autopsies shall be performed without the consent of a legally authorized agent of the deceased.
- b. All autopsies shall be performed by a qualified pathologist or his/her designate.
- c. A copy of the preliminary autopsy report will be included in the Patient's health record within 72 hours of the autopsy. The final copy of the autopsy report will be included in the Patient's health record within 60 working days of the autopsy.

3.9.3 See also "Care of the Patient After Death" Policy.

3.10 ORGAN AND TISSUE PROCUREMENT

3.10.1 Practitioners will follow all applicable HPEI organ and tissue donation policies and procedures and comply with the *Human Tissue Donation Act (PEI)*.

3.10.2 Where appropriate, it is the responsibility of all Practitioners to discuss and encourage organ and tissue donation with the Patient and/or his/her Legal Representative.

3.11 QUALITY ASSURANCE AND RISK MANAGEMENT

3.11.1 Each member of the QEH Medical Staff shall participate in Quality Assurance and Risk Management activities under the direction of their Clinical Department/Program Head. These may include Morbidity and Mortality Rounds, individual or departmental practice audits and reviews, educational sessions focused on quality of care or risk issues, and quality improvement activities pursuant to Part IV of the *Health Services Act*.

3.11.2 Members of the QEH Medical Staff are responsible to report adverse events to their Clinical Department/Program Head and to Risk Management. An adverse event is an unexpected, undesired and harmful incident directly associated with the care or services provided to the patient, rather than to the patient's underlying medical condition. The Clinical Department /Programme Head will report such adverse events to the QEH Medical Director.

3.11.3 In the event of the occurrence of an adverse event, each member of the QEH Medical Staff shall disclose that event to the patient/family, following Disclosure of Adverse Events Policy 1-10-55-30.

PART B. PRACTITIONER-RELATED PROVISIONS

3.12 ON-CALL AND SERVICE COVERAGE

3.12.1 Each member of the Active and Associate Medical Staff shall participate in such on-call duties and duty rosters as may be determined by the Head of the Department or Program in which they practice and shall be governed by the applicable Medical Staff policy (#7309-03).

3.12.2 Each Practitioner shall ensure safe and effective on-call coverage for the Patients for whom they are the Most Responsible Practitioner. Practitioners, when unavailable for whatever reason, will make

arrangements with another Practitioner(s) for the care of their Patients. This may be accomplished by specific arrangements or by participating in an on-call schedule with other Practitioners who have similar and appropriate Clinical Privileges.

- 3.12.3 Practitioners and their Clinical Department Head(s) or designate(s) and/or the QEH Medical Director shall jointly establish and maintain reasonable and effective on-call schedules in order to provide safe and effective coverage and care to Patients. Responsibilities of an on-call Practitioner include but are not limited to:
- a. Responding appropriately to calls and requests from other Practitioners and other health professionals regarding Patients for whom they are responsible while on-call or about whom they have been consulted. Practitioners shall attend Patients appropriately and in a timely fashion.
 - b. Discussing with a referring or consulting Practitioner the urgency of the consultation and, when possible, offering advice to a referring Practitioner in advance of the consulting Practitioner attending the Patient. Such discussion may include arranging in-person attendance at an appropriate time and location, and follow-up of cases not requiring emergent assessment.
 - c. Working collaboratively with a referring Practitioner to stabilize the Patient and provide urgent care if applicable and as required, and consistent with the level of resources available.
 - d. Working collaboratively with a referring Practitioner to coordinate the timely admission or appropriate transfer of the Patient as required. This includes communicating directly with the receiving Practitioner, when applicable.
- 3.12.4 It is expected that a referring Practitioner will limit evening and night-time consultations to urgent or emergent cases. Referrals for non-urgent/non-emergent cases should be arranged during day-time hours. A non-urgent acute care consultation should be completed within twenty-four hours of the request, unless otherwise agreed to by the referring and consulting Practitioners. In the event that the consulting Practitioner is the sole practitioner in a specialty or subspecialty, or part of a 2 person group, non-urgent consultations should be completed within 48 hours of the request, unless otherwise agreed to by the referring and consulting Practitioners. Non-urgent consultations that may be appropriately performed on an out-patient basis should be so arranged, and should not delay discharge of the Patient.
- 3.12.5 Practitioners and QEH/HPEI medical administrative leaders shall work jointly to ensure that on-call schedules do not place work demands on individual Practitioners that prevent the Practitioner from providing safe Patient care and service coverage. QEH/HPEI medical administrative leaders shall work collaboratively with Practitioners to resolve such situations when they arise.
- 3.12.6 Practitioners shall manage their other concurrent clinical activities in order to ensure that he/she can safely and appropriately fulfill his/her on-call duties and responsibilities.
- 3.12.7 Practitioners, initially amongst themselves, and, if required, subsequently with their Clinical Department Head or designate(s) and/or QEH Medical Director shall work collaboratively to resolve any issues or disputes related to appropriate on-call coverage and/or on-call schedules. If unsuccessful, the issue or dispute shall be referred to the Executive Director of Medical Affairs for resolution as required.

- 3.12.8 Despite the foregoing, in the event that that the Most Responsible Practitioner (or designate) is not available to attend one of their patients, the Clinical Department or Program Head shall have the authority to call any appropriate member of the staff to attend that patient who in his/her judgment stands in need of attention.

3.13 PRACTITIONER PATIENT CARE ROUNDS

- 3.13.1 Practitioners should strive to complete daily Patient care rounds prior to 1000 hours. Practitioners with large, complex in-patient practices should complete daily Patient care rounds as early as possible.
- 3.13.2 When appropriate, and in order to provide optimal Patient care, the Practitioner should undertake additional Patient assessments as required.
- 3.13.3 Sections 3.12.1 and 3.12.2 of these Rules do not obviate the responsibility of the Most Responsible Practitioner or consulting Practitioner(s) to respond or assess Patients who require more frequent visits because of their condition or upon staff request.

3.14 SUPERVISION OF MEDICAL STUDENTS AND RESIDENTS

- 3.14.1 At any given time, each Medical Student and Resident shall have one Practitioner in the Facility or the community designated as the supervisor of that trainee's experience.
- 3.14.2 In all cases involving supervision of Medical Students and Residents, the Most Responsible Practitioner must maintain sufficient knowledge of the Patient to ensure the Patient is receiving safe and appropriate care, and must remain readily available to assist the Medical Student or Resident, or intervene if necessary.
- 3.14.3 When involved in the education of trainees (Medical Students, Residents and other health care learners), Practitioners shall supervise all Procedures undertaken by a trainee. However, if the trainee has obtained and demonstrated the necessary skills, and is considered competent, to perform Procedures independently, the supervising Practitioner or designate shall only be required to be available to assist or intervene if necessary.
- 3.14.4 When involved in the education or supervision of trainees, Practitioners must ensure that the trainees are aware they have the following responsibilities:
- a. to explain his/her role in the Patient's care to the Patient and/or his/her Legal Representative;
 - b. to inform the Patient and/or his/her Legal Representative of his/her name and that of the Most Responsible Practitioner;
 - c. to notify the supervising Practitioner and/or the Most Responsible Practitioner when a Patient's condition is deteriorating, the diagnosis or management is in doubt, or where a Procedure with possible serious adverse effects is planned;
 - d. to inform the Most Responsible Practitioner and/or supervising Practitioner when discharge is appropriate and planned;
 - e. to notify the Most Responsible Practitioner and/or supervising Practitioner of all Patients assessed on behalf of the Practitioner; and
 - f. to assess all referrals and consultations in a timely fashion as appropriate to the Patient's condition.

3.15 PRACTITIONER-SUPERVISED HEALTH PROFESSIONALS

- 3.15.1 At any given time, each Practitioner-supervised Health Professional shall have one Practitioner in the Facility or Site of Clinical Activity designated as his/her supervisor.
- 3.15.2 In all cases involving supervision of a Practitioner-supervised Health Professional, the Most Responsible Practitioner must maintain sufficient knowledge of the Patient to ensure the Patient is receiving safe and appropriate care, and must remain readily available to assist the Practitioner-supervised Health Professional, or intervene if necessary.
- 3.15.3 Practitioners shall supervise all Procedures undertaken by a Practitioner-supervised Health Professional. However, if the Practitioner-supervised Health Professional has obtained and demonstrated the necessary skills, and is considered competent, to perform Procedures independently, the supervising Practitioner shall only be required to be available to assist or intervene if necessary.
- 3.15.4 When supervising a Practitioner-supervised Health Professional, the Practitioner must ensure that the Practitioner-supervised Health Professional is aware of his/her responsibilities which may include, but are not limited to, one or more of the following:
 - a. to explain his/her role in the Patient's care to the Patient and/or his/her Legal Representative;
 - b. to inform the Patient and/or his/her Legal Representative of his/her name and that of the Most Responsible Practitioner;
 - c. to notify the supervising Practitioner and/or the Most Responsible Practitioner when a Patient's condition is deteriorating, the diagnosis or management is in doubt, or where a Procedure with possible serious adverse effects is planned;
 - d. to inform the Most Responsible Practitioner and/or supervising Practitioner when discharge is appropriate and planned;
 - e. to notify the Most Responsible Practitioner and/or supervising Practitioner of all Patients assessed on behalf of the Practitioner; and
 - f. to assess all referrals and consultations in a timely fashion as appropriate to the Patient's condition.

3.16 DESIGNATION OF MOST RESPONSIBLE PRACTITIONER/TRANSFER OF RESPONSIBILITY

3.16.1 IDENTIFICATION OF MOST RESPONSIBLE PRACTITIONER

- a. Every Patient admitted to a Facility, or who receives emergent, urgent or elective evaluation or treatment on an ambulatory or "Day Procedure" basis in a Facility, shall have an identified Most Responsible Practitioner. The identity of the Most Responsible Practitioner shall be documented in the Patient's health record and the Patient shall be informed of his/her name by the Practitioner, his/her designate, or the nursing staff responsible for the Patient's care. The Most Responsible Practitioner has the duty, responsibility and authority to direct all medical care for that Patient while in the Facility, and to make reasonable efforts to ensure continuity of care following discharge.
- b. The Most Responsible Practitioner may designate any agreeable Practitioner(s) to provide concurrent care where this will provide benefit to the Patient. However, such designation will not have the effect of transferring ultimate responsibility for the Patient from the Most Responsible Practitioner.

3.16.2 KEY ACCOUNTABILITIES AND RESPONSIBILITIES

The Most Responsible Practitioner is accountable and shall assume responsibility for the overall care provided to the patients under their care and shall:

- a. Be aware of each patient for whom they are responsible.
- b. Assess and examine the patient, document his/her findings and issue the acceptable orders:
 - i. As warranted by the patient's initial condition;
 - ii. Within 24 hours of admission or acceptance of transfer of care or sooner, depending on the patient's condition.
- c. Communicate the patient's clinical status to the Patient, the family/legal guardian and the other members of the health care team as appropriate.
- d. Ensure that each patient is seen by a physician or his/her designate as often as the patient's condition warrants but not less than once each day while the patient remains under his/her care until such time as the patient is no longer designated an acute care patient.
- e. Complete progress notes in accordance with QEH/HPEI documentation standards.
- f. Undertake transfer of care arrangements and initiate consultations as required and to communicate such arrangements to the Patient, the family/legal guardian and the other members of the health care team.
- g. Be available, in person or by appropriate communication channels, 24 hours a day, seven (7) days a week or clearly articulate the delegation to a designate with appropriate QEH privileges.
- h. Manage patients proactively, establishing a care plan and expected date of discharge within 48 hours of admission; monitoring and actively managing the progress of the patient toward the goals of the care plan.

3.16.3 TRANSFER OF RESPONSIBILITY

- a. The designation and responsibilities of the Most Responsible Practitioner may be transferred from one Practitioner to another provided that the receiving Practitioner agrees and has the appropriate Clinical Privileges. The Most Responsible Practitioner shall document the transfer, and the receiving Practitioner shall document acceptance, in the Patient's health record. Routine acceptance by the receiving Practitioner as part of routine call-group coverage will not need to be documented, except in extenuating circumstances.
- b. The Most Responsible Practitioner or designate shall ensure the Patient and/or his/her family, the Patient's Legal Representative, and other Practitioners involved in providing continuing care to the Patient are informed of the transfer.
- c. The Most Responsible Practitioner shall make reasonable efforts to inform the patient's personal/family physician, and other Practitioners providing care to the Patient in the community, of the Patient's course in hospital, disposition and treatment plan following discharge.

3.17 ABSENCE FROM CLINICAL PRACTICE, RETIREMENT RESIGNATION

- 3.17.1 During an absence from clinical practice, a Practitioner shall ensure requirements are met for coverage of all his/her responsibilities, and shall identify an alternative Practitioner to assume those responsibilities and to serve as Most Responsible Practitioner for his/her admitted Patients.

QUEEN ELIZABETH HOSPITAL MEDICAL STAFF RULES

The Practitioner providing coverage must have the appropriate Clinical Privileges. The Practitioner will document the identity of the covering Practitioner in the Patient's health record and shall inform the Patient, and/or his/her family and/or the Patient's Legal Representative.

- 3.17.1.1 Coverage for Patients during an absence of less than or up to ninety-six hours may be provided through the on-call schedule of the service or group in which the Practitioner participates, or by alternative but specific prior arrangement.
 - 3.17.1.2 During an absence of greater than ninety-six hours, the provisions of section 3.16.3 of these Rules for the formal transfer of responsibility must be fulfilled.
 - 3.17.1.3 For an absence of greater than 42 consecutive days, a formal leave of absence is required and must be approved in advance by the QEH Medical Director or designate upon the recommendation of the Clinical Department or Program Head(s) or designate(s). The recommendation and approval to grant a leave of absence will be based on consideration of the reason(s) for the request, the responsibilities of the Practitioner, workforce needs and the Practitioner Workforce Plan, and any other relevant matters and is governed by section s38 (Leave of Absence for Non-Medical Reasons) and 39 (Leave Due to Illness and/or Disability) of the Bylaws. Only in exceptional circumstances will the length of a leave of absence exceed one year.
- 3.17.2 Any member of the QEH Medical Staff may resign by delivering written notice of resignation to the Medical Director, with a copy to the Executive Director of the Queen Elizabeth Hospital and the Executive Director of Medical Affairs.
- 3.17.2.1 A member of the QEH Medical Staff who proposes to resign shall give as much notice as is practicable in the circumstances. Unless otherwise specified in Departmental policy, minimum notice will be at least eight (8) weeks.
 - 3.17.2.2 The age at which a member of the Active Staff will retire from Active hospital service will be determined by the individual physician, presuming that he or she continues to demonstrate sound clinical judgment and reasonable cognitive and technical skills. It is expected that non-surgical clinicians may cease to be eligible for Active Staff privileges upon attaining their seventy-fifth (75th) birthday. Surgeons may not be granted primary O.R. privileges beyond their seventieth (70th), and they may no longer be credentialed as Active Staff beyond their seventy-fifth (75th) birthday.
- 3.18 GOVERNANCE OF PROFESSIONAL CONDUCT AND MEDICAL ETHICS
- 3.18.1 The professional conduct of the members of the QEH Medical Staff shall be governed by the Code of Ethics of the Canadian Medical Association (physicians), the Code of Ethics of the Canadian Nurses Association (nurse practitioners), the Code of Ethics of the Canadian Dental Association (dentists), the regulations of the applicable provincial licensing bodies, by the HPEI Medical Staff Bylaws, the Rules and Regulations of the Medical Staff of HPEI and by the Rules of the QEH Medical Staff.
 - 3.18.2 Violation of ethical principles may be cause for disciplinary action as established in the Bylaws.

3.18.3 Practitioners may seek the advice of the Health PEI Clinical Ethics Committee in difficult decisions or relationships that are related to human and Patient rights, health and safety of the Patient or staff and other Practitioners, multiculturalism, issues of spirituality, faith and religion or other ethical considerations.

3.19 RESEARCH

Practitioners are encouraged to participate in, and/or support, approved research activities within HPEI and to consider recommending the participation of their Patients in relevant and approved research activities.

3.20 DISRUPTIVE BEHAVIOUR IN THE HEALTH CARE WORKPLACE

Practitioners shall be familiar with the QEH Code of Conduct (Medical Staff Policy 7309-10). This policy will be applied as a framework when addressing complaints/allegations of disruptive behaviour by physicians.

PART C. DOCUMENTATION, RECORDS AND RECORD KEEPING

3.21 PERSONAL DIRECTIVES

- a. Each Practitioner shall be governed by QEH/HPEI policy and procedures on personal directives.
- b. When a Patient is admitted, it should be determined if he/she has a personal directive. If so, the Most Responsible Practitioner should discuss the provisions of the personal directive with the Patient and/or his/her Legal Representative, and ensure that a copy is included in the Patient's health record. A personal directive may also include any requests that the Patient may have with regard to organ and tissue donation.
- c. Patient health record Information transferred to other Facilities or health care institutions will include a copy of the Patient's personal directive.

3.22 HEALTH RECORDS

3.22.1 GENERAL GUIDELINES:

- a) All Practitioners shall complete their health records within the specified period(s) of time using the systems made available for dictation and electronic signature
- b) HPEI has a legal obligation to protect health information. The information belongs to the Patient but the Health Records Department is the legal custodian of the health record. Original or copies of health records are not to be removed from the QEH unless authorization is received from HPEI Health Information Management, or unless in compliance with a legally valid Subpoena Duces Tecum or a legally valid Search Warrant.
- c) Confidentiality of Patient medical information is paramount. Practitioners must respect
- d) and adhere to relevant policies governing privacy and access to health records.

3.22.2 DOCUMENTATION STANDARDS

3.22.2.1 GENERAL STANDARDS

- A. A health record shall be maintained for each Patient who is evaluated or treated, or who receives emergency, inpatient or ambulatory care. All significant clinical information pertaining to a Patient shall be incorporated in the Patient's health record.
- B. All Practitioners making entries into a Patient's health record shall include documentation of the date (YYYY/MMM/DD) and time of the entry, his/her role/title and, in the case of written entries, an identifiable signature, preferably accompanied by his/her printed name. Where available, the use of the electronic signature is mandatory. A handwritten, original signature is required in all other circumstances (with the exception of existing delegated authentication processes).
- C. Practitioners shall follow HPEI policy on approved health record abbreviations.
- D. All health records must be completed within 14 days of the record having been made available to the Practitioner after discharge or death.

3.22.2.2 ADMISSION (HISTORY AND PHYSICAL) NOTE

- a. The Most Responsible Practitioner is responsible for an admission note documenting the history, pertinent physical examination and plan of management for all Patients admitted under his/her care.
- b. Completion of an admission note may be delegated to a Medical Student or Resident. The Most Responsible Practitioner, nevertheless, remains responsible for ensuring the recorded information is complete and accurate.
- c. Admission Note Requirements:
 - I. Every inpatient must have an admission note completed within twenty-four hours following admission, except in the case of a surgical emergency, in which case the admission note must be completed prior to the surgical operation.
 - II. For surgical admissions only, if a complete assessment (history and physical) has been performed within one year prior to admission, such as in the office of a Practitioner, a copy of this report may be used as an admission note in the Patient's health record, provided that an update is recorded in the chart at the time of admission. All such recorded information must be authenticated and validated by the Most Responsible Practitioner or his/her designate within twenty four hours of admission.
 - III. For Day Surgical Admissions, a hand written admission note by the surgeon is acceptable.
 - IV. For obstetrical Patients an original or reproduction of the prenatal record is acceptable as an admission note but must be authenticated and validated by the Most Responsible Practitioner or his/her designate.
 - V. For stable Patients transferred from one Facility to another to non-critical care beds, a note detailing the reasons for the transfer and the condition of the Patient upon arrival at the receiving Facility, together with an electronic or paper copy of the admission note and relevant health records from the sending Facility, shall constitute a 24 hour admission holding note for the receiving Facility. After that point, a complete admission note shall be recorded on the chart.

- d. Recommended minimum content of an Admission Note:
 - I. Identification information with respect to the Patient
 - II. The reason(s) for admission, or chief complaint.
 - III. Details of present illness, including, when appropriate, assessment of the Patient's emotional, behavioural and social status.
 - IV. Relevant past medical history, review of body systems, current medications, presence or absence of allergies, and relevant past social and family histories appropriate to the age of the Patient.
 - V. Details of a complete physical examination.
 - VI. Documentation of relevant recent or available laboratory or diagnostic imaging tests.
 - VII. A comprehensive list of active Patient care problems/issues with an appropriate differential diagnosis for each problem as required.
 - VIII. A statement of the conclusions drawn from the admission history and physical examination and an initial plan of management for the active problems.
 - IX. Level of care designation or a summary or copy of the Patient's personal directive if appropriate
 - X. Estimated length of stay and documentation of patient issues or circumstances that may prolong the length of stay or will require advanced discharge planning.

3.22.2.3 PROGRESS NOTES

- a. The Most Responsible Practitioner is responsible for recording and maintaining progress notes for Patients under his/her care. Progress notes must serve as a pertinent chronological record of the Patient's course in hospital as well as any change in condition, interpretation of the results of diagnostic tests and the effect of treatment.
- b. Documentation and maintenance of progress notes may be delegated to a Medical Student or Resident. The Most Responsible Practitioner, nevertheless, remains responsible for ensuring the recorded information is complete and accurate. The Most Responsible Practitioner must co-sign the progress notes of Medical Students but not those of a Resident.
- c. Daily progress notes are expected for Patients, unless the Patient is designated as Alternate Level of Care and is awaiting placement in a Convalescent Care, Community Care or Long Term Care facility, in which case progress notes shall be written at least 3 times weekly. Notwithstanding these guidelines, progress notes shall be completed whenever there is a significant change in the Patient's condition or management, and whenever unexpected events or outcomes occur. In emergency situations, progress notes may be required every few hours as the condition warrants.
- d. Recommended minimum content of Progress Notes:
 - I. Response to treatment.
 - II. Acute or unexpected changes in the Patient's condition.
 - III. Adverse reactions to drugs and/or other treatments.
 - IV. Interpretation of the results of diagnostic tests, particularly significant or unusual test results.
 - V. Fundamental decisions about ongoing management including but not limited to medication, invasive procedures, consultations, treatment goals, and decisions regarding level of care/resuscitation.

- VI. Invasive procedures not performed in an operating room.
- VII. Discharge plans.
- VIII. Documentation in the event of death, including the date and time of death.
- IX. Any other information as may be pertinent, such as temporary leaves, refusal of treatment or leaving against medical advice.

3.22.2.4 PRACTITIONER ORDERS

- a. Where available, electronic order entry is mandatory. If electronic order entry is not available, hand written orders must be documented on the approved order sheet with the time, date of the entry (YYYY/MMM/DD), and a legible signature, preferably accompanied by his/her printed name.
- b. The identity of the Practitioner(s) covering in the case of an absence of the Most Responsible Practitioner and all transfers of care between Practitioners shall be documented in the orders.
- c. Verbal and Telephone Orders:
 - I. Verbal orders will be accepted only when the Practitioner is in an emergent or procedural situation and is therefore unavailable to enter the order electronically or write the order on an approved form.
 - II. Telephone orders will be accepted in situations in which prompt or immediate direction for Patient care is required and the ordering Practitioner is not within the hospital, does not have computer access, or is being paged directly by a provider about a clinical situation which requires a new order. Facsimile (fax) transmission of orders written by the ordering Practitioner is preferred to telephone orders. Faxed orders must include the ordering Practitioner's legible signature, preferably accompanied by his/her printed name.
 - III. Verbal and telephone orders shall only be accepted and recorded by persons authorized to do so and in accordance with QEH/HPEI policy.
 - IV. Telephone orders communicated by a third party acting on behalf of the Practitioner shall not be accepted, unless such a person is another Practitioner or a resident. However, In emergency situations when the Practitioner cannot personally provide a telephone order, such orders may be relayed by a QEH staff member so long as the staff member doing so is physically present with, and can be heard by, the ordering Practitioner.
 - V. Verbal and telephone orders must be repeated back to the ordering Practitioner and will be signed by the authorized person to whom they were dictated, along with the name of the ordering Practitioner.
 - VI. Verbal and telephone orders shall be countersigned within twenty-four hours. Verification of verbal and telephone orders shall be the responsibility of the ordering Practitioner.
 - VII. Order sets shall be signed by the Practitioner for each Patient to whom they are applied.

3.22.2.5 OPERATIVE/PROCEDURE REPORTS

- a. Operative/Procedure reports are to be dictated or electronically entered in the health record within twenty-four hours of surgery.

- b. Recommended minimum content of operative/Procedure Reports:
 - I. identification information with respect to the Patient
 - II. title of the operation/procedure performed
 - III. pre-operative diagnosis/indication for the operation/procedure
 - IV. proposed operation/procedure (if different from procedure performed)
 - V. post-operative/procedure diagnosis
 - VI. type of anaesthesia
 - VII. diagnostic specimens collected/removed during the operation/procedure
 - VIII. operative/procedure findings
 - IX. description of operation/procedure (including the condition of the Patient during and at the conclusion of the operative procedure, and estimated blood loss)

3.22.2.6 ANAESTHETIC RECORDS

The anaesthetist shall record a pre-anaesthetic assessment on the anaesthetic record prior to the administration of any anaesthetic and shall complete and sign the anaesthetic record at the end of the operation/Procedure.

3.22.2.7 CONSULTATION REPORTS

- a. Consultation reports are to be written, dictated and/or electronically entered in the health record within twenty-four hours of assessment of the Patient
 - b. Recommended minimum content for Consultation Reports:
 - I. identification information with respect to the Patient
 - II. findings of the consultation and recommendations for management of the Patient.

3.22.2.8 TRANSPLANTATION

- a. When an organ or tissue is obtained from a living donor for transplantation purposes, the health records of the donor and recipient shall fulfill the requirements for an operative report pursuant to section 4.21.2.6 of these Rules
- b. When a donor organ or tissue is obtained from a deceased Patient, the health records of the donor must include the date and time of death, documentation by and identification of the physician who determined the death, and documentation of the removal of the organ or tissue.

3.22.2.9 SURGICAL PATHOLOGY REPORTS

Recommended minimum content of Surgical Pathology Reports:

- a. Identification information with respect to the Patient
- b. Site of origin of tissue and/or operation/Procedure and date performed/collected.
- c. The gross descriptions which shall contain adequate information regarding:
 - I. Type, size and/or weight of lesion/specimen(s)
 - II. Measurements of gross lesion/specimen(s)

- III. Description of gross lesion/specimen(s) margins
- IV. Relationship of gross lesion/specimen(s) to surgical margins
- V. The diagnosis with supporting microscopic findings if indicated.
- VI. The final diagnosis in tumour cases and sufficient information as to grade of tumour, where appropriate, and extent of disease for use in standard systems of grading and staging neoplasms. If a grading system is used, the name of the grading system shall be documented and the results indicated in the report.

3.22.2.10 DISCHARGE SUMMARIES

- a. The Most Responsible Practitioner at the time of discharge of the patient from the Facility is responsible for completing a discharge summary.
- b. Completion of discharge summaries may be delegated to a Resident or other authorized person.
- c. The Most Responsible Practitioner, nevertheless, remains responsible for ensuring that the discharge summary is accurate and comprehensive.
- d. Completion Requirements:
 - I. A discharge summary is required for each admission in a manner that is conducive to electronic access and distribution (i.e. dictation, direct electronic entry, and/or scanning).
 - II. Discharge summaries should be completed within 48 hours after the chart is made available to the Practitioner post-discharge.
- e. The Discharge Summary will follow the HPEI "Required Documentation for Discharge Summary" template. Recommended minimum content of a Discharge Summary:
 - I. Identification information with respect to the patient.
 - II. Most responsible diagnosis
 - III. Secondary diagnoses
 - IV. Procedures in hospital, including investigations and consultations.
 - V. Course in hospital, including complications and condition on discharge.
 - VI. Discharge medications – including medication reconciliation, documenting changes from admission medications
 - VII. Follow up instructions and discharge disposition (including who will follow up results, where applicable)

3.22.2.11 AUTOPSY REPORTS

When a hospital autopsy is completed, an autopsy report shall be included in the health record. HPEI shall take reasonable action to endeavour to obtain the reports of autopsies undertaken by the Coroner and have them included in the Patient's health record. Reports shall be completed within 60 working days of the autopsy,

3.22.2.12 EMERGENCY DEPARTMENT NOTES AND AMBULATORY/OUTPATIENT REPORTS

- a. All entries on emergency and ambulatory Patients must be documented by the Practitioner on the approved forms and shall include the time, date and identifiable signature, preferably accompanied by his/her printed name.

QUEEN ELIZABETH HOSPITAL MEDICAL STAFF RULES

- b. The Most Responsible Practitioner shall ensure the emergency department notes and ambulatory/outpatient records of all Patients in his/her care are completed.
- c. Completion of emergency notes or ambulatory/outpatient records may be delegated to Residents and other authorized persons. The Most Responsible Practitioner, nevertheless, remains responsible for ensuring the recorded information is complete and accurate.
- d. Completion Requirements
 - I. Every emergency department Patient must have an emergency department note and every ambulatory Patient must have an ambulatory/outpatient record completed within twenty-four hours.
 - II. To facilitate the ongoing provision of care, for each Patient who receives continuing ambulatory/outpatient care, a summary outlining the changes that have occurred since the last visit is required.
- e. Recommended minimum content of emergency department notes and ambulatory/outpatient records:
 - I. The reason(s) for the visit.
 - II. The relevant history of the present illness or injury and the physical findings, including the Patient's vital signs as clinically appropriate.
 - III. Diagnostic and therapeutic orders.
 - IV. Clinical observations, including the result of treatment.
 - V. Reports of diagnostic tests and surgery and Procedures, and their results.
 - VI. Reports of any consultations or telephone/verbal advice obtained.
 - VII. Final diagnosis or impression.
 - VIII. Patient disposition and any instructions given to the Patient and/or his/her family for care.
 - IX. Allergies and medications, both current and prescribed.
 - X. Referrals to another Practitioner and/or HPEI Professional Services

3.22.3 HEALTH RECORD COMPLETION EXPECTATIONS(SUMMARY)

All members of the Medical Staff shall complete health records within the following timelines using the systems made available for handwritten records, dictation, electronic entry, and signature.

TYPE OF REPORT	TIMELINES FOR COMPLETION
Admission Note (History, Physical Examination, Impression and Plan)	Within twenty-four hours following admission except in a surgical emergency, in which case the Admission Note is to be completed, if at all possible, prior to the surgical procedure. Elective Surgical Admission Notes may predate admission by up to one year; all such Admission Notes must be updated and validated by the admitting Practitioner within twenty-four hours of admission.
Verbal Practitioner Orders	Verified within twenty-four hours.
Operative Report	Within twenty-four hours of surgery.
Anaesthetic Record	At the time of surgery.
Discharge Summary	Within 48 hours of chart being made available for dictation.
Emergency Notes	Within twenty-four hours of visit.
Ambulatory/Outpatient Records	Within twenty-four hours of visit.
Consultation Reports	Within twenty-four hours (preferably upon completion of the consultation).
Autopsy Reports	Within 60 working days of the autopsy.
Progress Notes	Daily progress notes are recommended, unless the Patient is designated ALC-LTC in which case a weekly note is the recommended minimum. Notwithstanding these guidelines, progress notes shall be completed whenever there is a significant change in the Patient's condition or management, and whenever unexpected events or outcomes occur.
Health Record (after discharge or death)	Within 28 days of the chart having been assembled and made ready by the Health Records Department

3.22.4 CURTAILMENT OF CLINICAL PRIVILEGES FOR INCOMPLETE HEALTH RECORDS:

3.22.4.1 Curtailment of Clinical Privileges for incomplete health records.

- a. QEH Health Records Department staff will monitor the completion of Patients' health records by Practitioners.
- b. After a Patient has been discharged, the Patient's health record will be made available to the Practitioner in Health Records. A message shall be sent by the Health Records Department to the Practitioner's Message Centre indicating that the health record is available for completion.
- c. If at any time, the Practitioner accumulates any Patient health records that have been incomplete for more than twenty eight days after the chart has been assembled and made available by the Health Records Department ("delinquent" health records), the Health Records Management shall notify the Practitioner and the QEH Medical Director (warning letter). If the delinquent health records have not been completed within 14 days and unless the QEH Medical Director determines that there are extenuating circumstances, the Practitioner's Clinical Privileges within Health PEI shall be automatically curtailed. This curtailment of Clinical Privileges shall continue until all outstanding health records are completed.

- d. Curtailment of Clinical Privileges encompasses all inpatient and ambulatory activity within all Sites of Clinical Activity.

3.22.4.2 During the period of curtailment, the Practitioner in default shall be permitted and expected to:

- a. Continue to care for his/her own Patients (including any surgical care) admitted prior to the date of curtailment of Clinical Privileges.
- b. Fulfill his/her obligations with regard to on-call responsibilities during which time the Practitioner may treat, admit and consult on emergent cases and provide coverage for Patients under the care of his/her Clinical Department service / colleagues.
- d. Provide care for his/her personal maternity and newborn cases including admission where necessary.

3.22.4.3 During the period of curtailment, the Practitioner in default shall not be permitted to:

- a. Admit Patients, other than his/her own maternity and newborn Patients, while not on-call.
- b. Write orders (except while on-call) on his/her personal Patients who are admitted under the care of another Practitioner.
- c. Treat Patients in his/her Site(s) of Clinically Activity except to continue to care for Patients for whom he/she was the Most Responsible Physician prior to the administrative suspension.
- d. Perform surgery or Procedures, assist in performing surgery or Procedures or administer anaesthetics, except within the conditions described in sections 3.22.4.2 a), b) and c) above.
- e. Provide consultative services, except within the conditions described in section 3.22.4.2 b) above.
- e. Accept transfers of Patients from within or outside the Hospital, except within the conditions described in 3.22.4.2 b) above.

3.22.4.4 End of the Period of Curtailment

All Clinical Privileges will be reinstated upon completion of all incomplete Patient health records that led to curtailment. If the Practitioner fails to complete the Patient health records that led to the curtailment within fourteen days of the curtailment being imposed, a Complaint shall be initiated by the QEH Medical Director and a separate complaint shall be lodged with the College of Physicians and Surgeons of Prince Edward Island.

3.22.4.5 Repeated Curtailment

If the privileges of a member are curtailed four times in any consecutive 12 month period, his/her privileges shall be automatically reduced for a full 30 day period. During this period, the expectations and restrictions described in Sections 3.22.4.2 and 3.22.4.3 shall apply.

PART D. OTHER

3.23 DISASTER PLANNING/EMERGENCY PREPAREDNESS

As required, and according to HPEI and QEH Disaster/ Emergency Preparedness Plans each Practitioner shall participate in disaster and emergency preparedness planning/exercises, and in the actual activation/implementation of plans in the event of an external/internal disaster or public health emergency, including those resulting in major service disruption.

3.24 PHARMACY

Each Practitioner shall be governed by QEH/HPEI policies regarding the use of drugs and therapeutic agents. These include policies and procedures introduced by the QEH Medication Management Committee and its subcommittees, the Provincial Pharmacy and Therapeutics Committee and its subcommittees, those related to the Provincial Formulary.

3.25 COMMUNICABLE DISEASES

- a. Practitioners shall provide care within their area of expertise to all Patients, including those known or suspected of having transmittable infections. Practitioners shall also ensure that all appropriate precautions are taken to prevent transmission of these infections to others, including themselves.
- b. It is the duty of all Practitioners to take appropriate action to protect themselves and Patients from known, suspected or possible transmittable infections and conditions. Such action shall include compliance with basic infection control strategies, referred to as routine practices (also known as standard precautions), for every patient encounter. Additional precautions may be necessary for patients with pathogens transmitted by contact, droplet or airborne routes. As determined by a Medical Officer of Health, alteration and/or restriction of Practitioner duties or, when necessary, exclusion of the Practitioner from work may also be required as defined by the Practitioner's susceptibility to, and potential for transmission of, a communicable disease.
- c. Practitioners shall follow the current QEH/HPEI hand washing policies and procedures and the current QEH/HPEI isolation policies and procedures.
- d. The Most Responsible Practitioner shall be accountable for notifying the Chief Medical Officer of Health of all cases of communicable disease where such notification is required by law.

- Appendix A – Template for Development of Terms of Reference
 Appendix B – Coroner's Act Part II Duty to Report Death to Coroner (5(1) a – k)
 Appendix C – Definitions from the Health PEI Medical Staff By-Laws

APPENDIX "A"

Page No: - 1 -

Number:

Queen Elizabeth Hospital

TERMS OF REFERENCE			
Committee Name:			
<i>Date Adopted</i>	<i>Revision Date</i>	Approval Date by Committe	Approval Date By LMAC

1. PURPOSE:

2. COMMITTEE FUNCTIONS:

3. COMMITTEE RESPONSIBILITIES:

4. AUTHORITY:

5. ACCOUNTABILITY

Chair:	
Reporting:	
Accountability:	

Number:

Page No: - 2 -

6. MEETING LOGISTICS:

7. MEMBERSHIP:

8. RESOURCES:

9. COMMUNICATION WITH THE COMMITTEE

APPENDIX "B"

CORONER'S ACT – PART II

DUTY TO REPORT DEATH TO CORONER

- Duty to notify of a death 5.(1) Where a death has occurred in the province, or as a result of events that occurred in the province, every person shall immediately report the death to a coroner or a police officer , if the person has reason to believe that the death
- (a) occurred as a result of violence, accident, suicide or other cause other than disease, sickness or old age;
 - (b) occurred as a result of negligence, misconduct or malpractice;
 - (c) occurred suddenly and unexpectedly when the deceased had been in apparent good health;
 - (d) occurred under circumstances in which the body is not available because the body or part of the body
 - (i) has been destroyed,
 - (ii) is in a place from which it cannot be recovered, or
 - (iii) cannot be located;
 - (e) occurred within 10 days after a surgical procedure or while the deceased was under or recovering from anaesthesia;
 - (f) occurred as a direct or immediate consequence of the deceased being engaged in employment, an occupation or a business;
 - (g) was a stillbirth that occurred without the presence of a duly qualified medical practitioner;
 - (h) occurred while the deceased was detained or in custody involuntarily pursuant to law in a jail, lock-up, correctional facility, medical facility or other institution;
 - (i) occurred while the deceased was detained by or in the custody of a police officer;
 - (j) occurred while the deceased was under the care, custody or supervision of the Director of Child Protection; or
 - (k) occurred in circumstances that require investigation

APPENDIX “C”

Definitions from the Health PEI Medical Staff Bylaws

Definitions

These Bylaws are developed to be gender neutral. Therefore references to gender are made as they/their/them and are meant to encompass both genders.

In these Medical Staff Bylaws, the following definitions apply:

- (a) “Applicant” means a person who has applied for appointment to the Medical Staff under Parts IV, V, VI or VII of these Bylaws;
- (b) “Appointment” means the process by which a physician or dentist or nurse practitioner becomes a member of the Medical Staff of Health PEI;
- (c) “Board” means those persons appointed as members of the Board of Directors of Health PEI by the Lieutenant Governor in Council pursuant to Section 7(1) of the Health Services Act, R.S.P.E.I. 1985. Cap H-16 as amended;
- (d) “Business day(s)” means a day(s) other than a Saturday, Sunday or any day on which the principal chartered banks located in the City of Charlottetown are not open for business during normal banking hours;
- (e) “Bylaws” means these Medical Staff Bylaws herein;
- (f) “Chief Executive Officer” (CEO) means the person appointed by the Board of Health PEI as Chief Executive Officer within the meaning of Sections 11(1) or 11(2) of the Health Services Act, responsible to the Board for the leadership of Health PEI and to carry out the general management of the facilities and programs operated by Health PEI in accordance with the bylaws, rules and policies of Health PEI;
- (g) “Complaints Review Committee” means the sub-committee of the Provincial Medical Advisory Committee to which a complaint regarding a member of the Medical Staff may be referred for a review and recommendation as set out in these Bylaws;
- (h) “Confirmed in Writing” means by letter, either typed or handwritten, or by electronic means such as email;
- (i) “Consultative Services” means those services provided by physicians, dentists or nurse practitioners of recognized professional ability who are not members of another category of Medical Staff who give consultations on request to any member of the Medical Staff or in cases where consultation is required by Departmental or Program policies;
- (j) “Delegate” means that person who has been authorized to act or perform a task on behalf of another person;

QUEEN ELIZABETH HOSPITAL MEDICAL STAFF RULES

- (k) “Dentist” means a member of the Medical Staff who is duly licensed by the Dental Association of Prince Edward Island and who is entitled to practice dentistry pursuant to the Dental Profession Act;
- (l) “Dental Staff” means those oral and maxillo-facial surgeons who have been appointed as a member of the Medical Staff by the Board and those dentists who have been appointed as members of the Medical Staff by the Board;
- (m) “Department” means a component of the Medical Staff composed of members with common clinical or specialty interest as recommended by the Executive Director of Medical Affairs in consultation with their Local Medical Advisory Committee;
- (n) “Department Head” means a member of the Medical Staff in charge of and responsible for the operation of a Department who is responsible to the Network/Site Medical Director;
- (o) “Executive Director of Medical Affairs” means the physician appointed as Executive Director of Medical Affairs by the Chief Executive Officer and responsible for medical services provided within Health PEI pursuant to the Bylaws;
- (p) “Executive Directors” means those three senior administrative staff appointed by the Chief Executive Officer pursuant to Section 14(6);
- (q) “Health Facility” means any building or premise which the Minister of Health and Wellness or Health PEI owns or leases to provide health services; a “health facility” specifically does not include any building or premise, owned or leased by fee-for-service physicians, to provide health services;
- (r) “Health PEI” means the Crown Corporation established under the Health Services Act;
- (s) “Health PEI Quality and Risk Coordinators” means the individuals who are responsible for providing leadership in quality management and risk management to effect improved client/patient care and services for an assigned geographic/program area in Health PEI;
- (t) “Impact Analysis” means a study conducted by the Executive Director of Medical Affairs, or delegate, in consultation with a Department and/or Program to determine the impact upon the resources of Health PEI of a proposed appointment of any person to the Medical Staff in that Department or Program;
- (u) “Local Medical Advisory Committee” (LMAC) means those committees appointed by the Chief Executive Officer in consultation with the Executive Director of Medical Affairs pursuant to Section 18(1) of these Bylaws;
- (v) “Local Medical Staff Association”(LMSA) means the organized body of physicians, nurse practitioners and dentists who are affiliated with a particular hospital or the unaffiliated physician group, or the unaffiliated nurse practitioner group and hold membership with their respective professional associations;
- (w) “Member” means a member of the Medical Staff;
- (x) “Medical Staff” means those physicians and dentists and nurse practitioners who have been appointed as members of the Medical Staff by the Board and who hold a licence to practice medicine or dentistry or as a nurse practitioner in Prince Edward Island;

- (y) “Minister” means the Minister of Health and Wellness for the Province of Prince Edward Island or any other Minister duly appointed by the Province of Prince Edward Island to administer the Health Services Act;
- (z) “Medical Schools” means those University schools of Medicine approved by the College of Physicians and Surgeons of Prince Edward Island;
 - (aa) “Network” means a geographic area within which a team of health providers deliver and coordinate primary health care services to Islanders from various sites;
 - (bb) “Site” means the health facilities operated under Prince County Hospital or the Queen Elizabeth Hospital;
 - (cc) “Network/Site Medical Director” means the person(s), appointed by the Executive Director of Medical Affairs, who is responsible for particular hospitals or programs of Health PEI as outlined in Section 8(1) of these bylaws;
 - (dd) “Nurse Practitioner” (NP) means a member of the Medical Staff who is entitled to practice pursuant to the Registered Nurses Act of Prince Edward Island and holds a license that is endorsed with a nurse practitioner’s endorsement under Section 15 of their license;
 - (ee) “PEI Family Medicine Residency Program” means a community-based family medicine training program, associated with Dalhousie University Medical School, to facilitate the clinical experiences through a series of family medicine and specialty rotations for medical residents, who come to PEI to train in Family Medicine;
 - (ff) “Physician” means a member of the Medical Staff who is entitled to practice medicine pursuant to The Medical Act and who is duly licensed by the College of Physicians and Surgeons of Prince Edward Island;
 - (gg) “Physician Leader” means a member of the Medical Staff appointed or elected to a position of responsibility pursuant to these bylaws;
 - (hh) “Policies and Procedures” means those policies and procedures to govern the application of the Medical Staff Bylaws that have been recommended by the Provincial Medical Advisory Committee, and approved by the Board of Health PEI;
 - (ii) “Program(s)” is the term used to describe a group(s) of clinical services within Health PEI that are directed toward meeting the health care needs of a specific group of patients, in a patient focused and interdisciplinary manner;
 - (jj) “Program Head” means a member of the Medical Staff in charge of and responsible for the operation of a Health PEI Program and who is responsible to the Executive Director of Medical Affairs;
 - (kk) “Province Medical Advisory Committee” (PMAC) means the advisory committee of the Medical Staff to the Health PEI Board on medical, nurse practitioner and dental matters;
 - (ll) “Presidents’ Council” means the five (5) Presidents of their respective Local Medical Staff Associations;

QUEEN ELIZABETH HOSPITAL MEDICAL STAFF RULES

- (mm) "Professional Regulatory Authority" means, in the case of a physician, the College of Physicians and Surgeons of Prince Edward Island and in the case of a dentist, the Dental Council of Prince Edward Island and in the case of a nurse practitioner, the Association of Registered Nurses of Prince Edward Island;
- (nn) "Privileges" means the rights granted by the Board in accordance with these bylaws to a physician or dentist or nurse practitioner to provide professional services as outlined by their privileges to admit, register, diagnose, treat or discharge patients in respect to a facility, program or service operated or delivered by Health PEI;
- (oo) "Rules and Regulations" means those rules and regulations governing the Medical Staff of Health PEI which have been recommended by the Provincial Medical Advisory Committee and approved by the Health PEI Board;
- (pp) "Senior Management Team" means the Executive Director of Medical Affairs and the Executive Directors of various programs and facilities operated by Health PEI reporting directly to the Chief Executive Officer of Health PEI;
- (qq) "Temporary Privileges" means the right to practice in the facilities and programs operated by Health PEI that is granted to a member of the Medical Staff for a specified period of time in order that they may provide a specific service;
- (rr) "Unaffiliated Physician" means a physician who is engaged in a clinical community practice in PEI who may be appointed to the Medical Staff with no admitting privileges at a Health PEI hospital or long-term care facility.