TILLSONBURG DISTRICT MEMORIAL HOSPITAL (TDMH)

PROFESSIONAL STAFF RULES AND REGULATIONS

TDMH Professional Staff Rules and Regulations – Revised May 2013
Approved by the Medical Staff Committee: June 12, 2013
Approved by the Medical Staff: June 19, 2013
Approved by the Board of Directors: June 24, 2013

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DEFINITIONS

I. Definitions

The Professional Staff Rules and Regulations, the following words and phrases shall have the following meanings, respectively:

i) "Accreditation" means the status of accreditation evidenced by the certificate of the Accreditation Canada;

ii) "Act" means the *Corporations Act* (Ontario), and where the context requires, includes the Regulations made under it;

iii) "Administrator" means Chief Executive Officer as defined in section 1 of the Public Hospitals Act, the Chief Executive Officer of the Corporation;

iv) "Board" means the Board of Directors of the Corporation;

v) "By-Law" means any By-Law of the Corporation including the Professional Staff Bylaws from time to time in effect;

vi) "Chair" means Chair of the Medical Advisory Committee appointed by the Board;

vii) "Chief Executive Officer" means, in addition to 'administrator' as defined in section 1 of the *Public Hospitals Act*, the Chief Executive Officer of the Corporation;

viii) "Chief of Staff" means a member of the Professional Staff appointed by the Board to organize the Professional Staff to ensure that the quality of care given to all patients in the Hospital is in accordance with policies established by the Board and Chair the Medical Advisory Committee.

ix) "Delegate" means another physician, a registered nurse, or a registered practical nurse appointed by the primary physician to provide care to a patient in the Hospital.

x) "Head of a Department" means a member of the Professional Staff appointed by the Board to be responsible for the professional standards and quality of medical care rendered by the members of that Department at the Hospital;

xi) "College" means, as the case may be, the College of Physicians and Surgeons of Ontario, the Royal College of Dental Surgeons of Ontario, or the College of Nurses of Ontario;

xii) "Consultant" means a physician/dentist/nurse practitioner who is qualified by both experience and training in a particular area to give an opinion on the condition in question.

xiii) "Corporation" means Tillsonburg District Memorial Hospital ("TDMH), 167 Rolph Street, TIllsonburg, Ontario N4G 3Y9.

ix) "Dental Staff" means the collection of legally qualified Dentists appointed by the Board to attend or perform dental services for patients in the Hospital;

xv) "Dentist" means a dental practitioner in good standing with the Royal College of Dental Surgeons of Ontario;

xvi) "Department" means an organizational unit of the Professional Staff to which members with a similar field of practice have been assigned;

xvii) "Extended Class Nursing Staff" RN(EC) means those Registered Nurses in the Extended Class in the Hospital, who are not employed by the Hospital and to whom the Board has granted privileges to diagnose, prescribe for or treat out-patients in the Hospital;

xviii) Health Information Custodian (HIC) us a person or organization that is responsible and accountable for the personal health information (PHI) it collects, uses and discloses. The HIC is responsible for the information management practices of its team members and affiliates. According to law, Tillsonburg District Memorial Hospital as an organization is a HIC.

xix) "Hospital" means Tillsonburg District Memorial Hospital;

xxi) "Professional Staff Human Resources Plan" means the plan developed andapproved by the Hospital's Chief Executive Officer in consultation with the Chief of Staff, Heads of Department based on the mission and strategic plan of the Corporation and on the needs of the community, which plan provides information and future projections of this information with respect to the management and appointment of Physicians, Dentists and Nurse Practitioners who are or may become members of the Medical Staff.

xxi) "Medical Advisory Committee" means the body who makes recommendations to the Board concerning Professional Staff matters, including but not limited to facilitating the development and maintenance of Rules and Regulations, Policies, ethical guidelines and procedures of the Professional Staff; approving the departmental clinical responsibilities of the Professional Staff.

xxii) "Medical Staff" mean those Physicians who are appointed by the Board and who are granted privileges to practise medicine in the Hospital;

xxiii) "Member" means a Member of the Corporation;

xxiv) "Most Responsible Physician" (MRP) means a member of the Professional Staff with privileges who will have overall responsibility for the care of the patient;

xxiv) "Patient" means, unless otherwise specified, any "in-patient" or "out-patient" of the Corporation;

xxv) "Physician" means a medical practitioner in good standing with the College of Physicians and Surgeons of Ontario;

xxvi) "Policies" means the Board, administrative, and clinical policies of the Corporation;

xxvii) "Privileges" or "privileges" means the rights and entitlements associated with the Professional Staff categories as provided for therein;

xxviii) "Professional Staff" means those physicians, dentists and extended class nurses who are appointed by the Board and who are granted specific privileges to practise medicine, dentistry, extended class nursing;

xxvix) "Professional Staff Appointment" means the appointment or assignment of a Professional Staff member to a Department or Service in the Hospital, by the Board, within the categorization of Active, Associate, Term, Locum Tenens, Courtesy, Senior and Temporary.

xxx) "Medical Staff Organization" includes the Medical Staff and Dental Staff as contemplated by the Public Hospitals Act;

xxxi) "Public Hospitals Act" means the *Public Hospitals Act* (Ontario), and, where the context requires, includes the Regulations made under it;

xxxii) "Registered Nurse in the Extended Class" or RN (EC) means a member of the College of Nurses of Ontario who is a registered nurse and who holds an extended certificate of registration under the Nursing Act, 1991;

xxxiii) "Rules and Regulations" means the Rules and Regulations governing the practice of the Professional Staff in the Hospital both generally and within a particular Department, which have been established respectively by the staff in general and the staff of the Department;

A. GENERALPURPOSE

I. Establishmentof Rules

a) The Medical Advisory Committee, from time to time, and where appropriate, upon the advice of a Department of the Professional staff may develop and implement policies, procedures and guidelines it deems necessary to support the professional work of the members of the Professional Staff is consistent with:
   (i) the mission, vision and values Tillsonburg District Memorial Hospital.
   (ii) the Public Hospitals Act and its Regulations
   (iii) and the Professional Staff By-Laws for Tillsonburg District Memorial Hospital.

II. Interpretation

a) The ProfessionalStaffRulesandRegulations of TDMH provide guidelines for the rights, privileges and responsibilities of a member of the Professional Staff. They provide the framework for the function of the Professional Staff as individuals and members of departments. They provide a structure whereby members of the Professional Staff participate in the hospital's planning, policy setting and decision-making;

b) The following rules and regulations are supplementary and additional to the Regulations of the Public Hospitals Act and are to be observed and complied with by all members of the Professional Staff subject as aforesaid;

c) Rules and Regulations are subordinate to the Hospital By-Laws;

d) Rules and Regulations shall not repeat by-laws or statutory provisions;

e) Rules and Regulations must be clearly written and specific to the needs and circumstances of the Professional Staff member.

III. Authority To Make Rules

a) The Medical Advisory Committee shall communicate such rules and regulations as may be necessary for the proper conduct of its work and to ensure a high quality of medical care for all TDMH patients.

b) Recommendations with respect to rules and regulations, the amendment or repealing of rules and regulations may be made at any regular meeting of the Medical Advisory Committee or at a special meeting called specifically for that purpose.

c) Recommendations with respect to the adoption, amendment or deletion of Rules and Regulations shall require a two-thirds majority of those present and entitled to vote at a meeting of the Medical Advisory Committee.

d) Such changes shall become effective when approved by the Board.

IV. GeneralStatementsofCompliance

GOVERNANCE

a) In addition to the Rules and Regulations, all members of the Professional Staff shall be familiar with and comply with the provisions of:
   (i) the Public Hospitals Act and the regulations there under respecting admission of patients to TDMH;
   (ii) the Professional Staff By-laws for TDMH; and
   (iii) all other policies, including ethical guidelines of TDMH.

PROVISIONOFCARE

a) All Professional Staff members will ensure that when clinical care or treatment is required for patients who present themselves to TDMH that such care is available and is delivered in accordance with established professional standards and accepted clinical practice protocols.

b) Refusal to deliver care to patients who present themselves to TDMH must only be based on clinical grounds and consistent with any policies of the Hospital relevant to the same.

B. PATIENTCARERESPONSIBILITIES

I. Town Call Physician

a) All family physicians who are on the Active or Associate Professional Staff at TDMH, under the age of sixty (60) must participate in the town call system, although exceptions to the policy might occur following special consideration of the Medical Staff Organization, such as diminished capacity for health reasons or surplus of resources.

II. Most Responsible Professional (MRP)- Physician

a) Inpatients who have no attending physician or whose attending physician (or alternate) is not available shall be seen and admitted by the physician on town call after office hours. The patient shall be transferred to his/her family physician or his/her alternate on his/her return. Weekend and evening/night care of inpatients whose MRP is unavailable is the responsibility of the Town Call physician.

b) For inpatients, the admitting Professional Staff member is the MRP until discharge or until the care of the patient is transferred to another Professional Staff member. The MRP duties are as outlined below in addition to duties outlined in other sections of these Rules and Regulations and the Professional Staff By-Laws.

c) When a physician is required, the nursing team members will contact the MRP or physician on-call for him/her and contact any other physicians involved only at the direction of the MRP. The physician on-call for the MRP assumes the role of MRP. The MRP must ensure that the physicians on-call is made aware or can readily be made aware of the complete condition of the patient.

c) The MRP (or his/her delegate) is responsible for:

i) ensuring an admission note, that sets out clearly the reason for the admission of the patient and orders are entered in the medical record and authenticated within 24 hours and in advance of any operative procedure or other intervention. An admission note in acute care includes a dictated history and a physical examination.
ii) all care of the patient during their hospital stay unless some aspect of the patient's care is clearly the accountability of a consultant involved in their follow-up or concurrent care;
iii) ensuring the health record is completed within 14 days of discharge. A completed health record is defined by the chart completion policy of Tillsonburg District Memorial Hospital;
iv) ensuring there is continuous coverage for the patient's care when the MRP is unavailable;
v) arranging for the transfer of the care of the patient to another MRP if for any reason he/she is unable to perform his/her professional duties.

Notes: 1) In the Post Anesthetic Care Unit, the anesthesiologist is the MRP.
2) During a procedure, the Professional Staff member performing the procedure is the MRP until that procedure is completed.

d) In accordance with the Professional Staff Bylaws, if a member of the Professional Staff is unable to perform his/her duties in the hospital, he/she shall notify the Head of the Department who shall arrange for another member of the Professional Staff to perform the duties and notify Chief of Staff/Chair of the Medical Advisory Committee.

III. GeneralAdmissions

a) Every patient admitted to TDMH shall be thereafter continuously in the care of a member of the Professional Staff who shall be responsible for the overall care and treatment of the patient, such member being designated in these rules as the MRP;

b) Any patient requiring admission to TDMH for dental treatment by a Dentist must be admitted by the MRP with the member of the dental department as the consultant.

c) A provisional diagnosis shall be given by the MRP (or delegate) before any patient is admitted.

Note: All patients receiving TDMH clinical or diagnostic service on an outpatient basis must be registered with the hospital.

IV. Emergency Department Admission Principles and Guidelines

Members of the Professional Staff shall comply with the Emergency Department principles and guidelines. These guidelines are maintained in order to enhance patient care, access and flow, to remove disagreement between physicians regarding appropriate transfer of patients to services and to clarify the admission process in the Emergency Room.

V. Discharges

a) A patient shall not be discharged from TDMH except on a verbal or written discharge order electronically authenticated by the MRP (or delegate). At the time of discharge the MRP (or delegate) shall ensure that the health record is complete, that the discharge medication reconciliation (Med Rec) is complete, and will dictate a discharge summary within 48 hours of discharge that includes all diagnoses.

VI. Transfers

a) The transfer of responsibility from one Professional Staff member shall be acknowledged on the health record by all parties to the transfer, and the MRP transferring the responsibilities shall thereupon complete the health record to the date and time of transfer.

b) In accordance with the Professional Staff By-Laws, responsibility for the care and treatment of a patient may be transferred to another member of the Professional Staff by the MRP or, upon direction of the patient, the Chief of Staff or delegate, shall be transferred to another member of the Professional Staff and the member to whom such responsibility has been transferred shall become the MRP.

VII. Consultations

a) The MRP may request a consultation from a specialist.

b) The consultant will document their arrival time in the appropriate space provided on the ED record.

c) The consultant shall examine the patient, and dictate a consultation of his/her findings, opinions and recommendations and electronically authenticate and date same.

d) When a consultation is requested, the requesting Professional Staff member shall indicate their wish regarding the type of consultation.

(i) Consultation only.
(ii) Consultation and concurrent care by specialist;
(iii) Consultation and transfer of total care to specialist.

e) When the consultant has assessed the patient, the consulting Professional Staff member will inform the requesting Professional Staff member regarding his/her willingness to provide the requested care. Irrespective of the type of consultation requested, it is the responsibility of the consultant to follow-up on any investigations that he/she has initiated and take appropriate action.

VIII. Hospital On-Call Guidelines

a) On-Call Professional Staff members are expected to be available to a request for their services from TDMH accordingly:

- First Call in ER:
  By telephone: immediately
  In person: within a maximum of 15 minutes when requested to attend. The physician is not required to remain on-site in the ER however, will be available via cell phone at all times.
- Second Call in ER:
  By telephone: available at all times via cell phone.
- On-Call Anaesthetist and On-Call Surgeon
  By telephone: within a maximum of 15 minutes
  In person: within a maximum of 45 minutes when requested to attend.

The **on-call response time** is defined as the amount of time elapsing between the first successful notification of an on-call Professional Staff member (verbally or by pager) of the need for his/her services.

IX. Transfer of Patients Between Hospitals

a) Comprehensive information regarding ambulance and non-ambulance medical transfer services for TDMH is available in the Emergency Department.

b) Patients shall be transferred from the care of a Professional Staff member at the sending hospital to the care of a Professional Staff member at the receiving hospital. The sending Professional Staff member or delegate should communicate directly with the receiving Professional Staff member prior to transfer and the receiving Professional Staff member must accept responsibility for the patient prior to transfer. Appropriate plans for medical care of the patient enroute should be developed by the responsible Professional Staff member of the sending hospital. These arrangements shall be documented on the patient's health record.

C. DOCUMENTATION

I. Consent

a) Consent to treatment, including completion of the Consent to Treatment form, if appropriate, is required and must be obtained prior to the patient receiving the treatment.

b) Consent that has been given by, or on behalf of the patient for whom the treatment was proposed, may be withdrawn at any time by the patient/SDM.

c) Treatment may be administered without consent only in an emergency situation, and then only following the guidelines for emergency treatment outlined in the Health Care Consent Act –

Emergency Treatment.

d) TDMH requires a written consent form, signed by the patient/SDM and the Health Practitioner proposing and/or performing the treatment, for certain procedures, as outlined in the Consent to Treatment Policies. In the case of a chronic patient, one written consent form is required that will be used on an ongoing basis.

e) Written, informed consent is required for patients receiving or likely to receive blood and/or blood products. This would include, but is not limited to, ALL patients for whom a group and reserve or cross match has been ordered.

f) Written, informed consent is required from patients/SDM and treating health care professionals before any photography is taken for any purpose, including:
   a. Patient care
   b. Education
   c. Public Relations
   d. Media coverage
   3. Social Media

II. Deaths/Autopsies

a) Upon the death of a patient, if the case is not a Coroner's Case, the MRP (or delegate) shall complete all required documentation as prescribed by the Public HospitalsAct, VitalStatisticsAct, and all other appropriate legislation and regulations, ensuring that such documentation is included in the Health Record. The MRP shall cause a copy of the Medical Certificate of Death to be filed in the Health Record within 24 hours after the death of the patient. If the case is a Coroner's Case, the hospital form should be completed by the MRP (or delegate).

b) Every Professional Staff member who has reason to believe that a person died in circumstances identified in s. 10)2) of the Coroner's Act shall immediately notify a coroner or a police officer of the facts and circumstances relating to the death. Refer to the Coroner'sAct.

c) Every Professional Staff member on the health care team should be aware of the value of the post-mortem examination in terms of quality assurance. The human body or any part or parts thereof may be used for determination of the cause of death. Direction should be sought from the coroner in circumstances where a conflict arises between the Coroner's Act and the intention to donate organs under the provisions of the Trillium Gift of Life Network Act.

d) Every patient/patient family has the right to request/authorize an autopsy. Authorizationforautopsy shall be discussed with each dying patient, or family of a deceased patient, at TDMH.

III. HealthRecords

Introduction:

a) This section outlines Professional Staff documentation requirements in a patient's health record in accordance with the Public Hospitals Act (R.R.O. 1990, Reg. 965), Personal Health InformationProtection Act(PHIPA2004) Accreditation Canada, Hospital By-Laws and Policies. It also incorporates linkages to general documentation principles for all health care providers responsible for documenting in a patient's health record.

Definition of a Health Record:

a) A patient's health record includes all information documented or recorded about a patient for the purpose of patient care. This includes but is not limited to pertinent facts of an individual's health history, including all past and present health conditions, illnesses and treatments. It is related to the patient's course of treatment while under the care of TDMH

and includes assessments, investigations, diagnoses, plan of care or treatment and interventions. It includes information that we generate, information that we have been provided to use by our Hospital partners and information we receive from other external sources. The health record in the Health Records department, health information maintained in other areas of the hospital(s), as well as information stored and available for use in the electronic patient record system. If information is perceived by a health care provider to be relevant to the care of the patient it should be documented in the health record.

b) Every patient assessed, treated or receiving care at TDMH shall be registered in the hospital's patient care system and an official health record will be created. Every patient visit to the hospital will also be documented in the hospital's patient care system, creating an encounter number that is required for visit specific documentation to be recorded in the Electronic Patient Record (EPR).

c) The patient's health record includes all written as well as electronic documentation as well as images (including photographs, video) taken to document a patient's care. The patient's health record may be stored in hard copy, microfiche, microfilm, optical disk, and in digital or electronic format. The health record compiled in a hospital for a patient is the property of the hospital (as the Health Information Custodian of record – TDMH) and will be kept in the custody of the administrator. The Health Records Department acts on behalf of the Administrator to assist with carrying out the organization's role as Health Information Custodian.

d) The official paper health record maintained by Health Record Services on behalf of the Administrator must not leave hospital premises at any time, except under order of the Courts, Coroner's Warrant, or when being archived or by written mutual agreement if TDMH transfers custodial responsibility for records to another individual or organization.

e) Transport of the official paper health record shall be coordinated by Health Record Services and occur only by the Manager of Health Information and Privacy, or delegate.

f) If, at any time, any agent of the Health Information Custodian is approved to remove health information from the hospital premises in electronic form, it must be de-identified or encrypted. Absolutely no patient identifiable information shall be stored on desktop computers or mobile computing devices unless encrypted. Patient's legal right to accuracy of personal health information: PHIPA grants patients the legal right to access their own personal health information (with only specific exceptions as directed in the Act and its Regulations) along with the right that their personal health information be accurate. The Act and its Regulations also grant patients the associated right to request an amendment or correction to information they consider to be inaccurate or incorrect.

g) Personal Health Information Protection Act, 2004 Chapter 3, Part V and How Do I Correct My Personal Health Information and TDMH Privacy Policy describes the legal rights of patients along with the process to follow if a patient wishes to request an amendment to their PHI. The document also describes the conditions under which the Health Information Custodian may refuse to grant such a request and the process to follow to do so.

General Documentation:

The following general documentation principles are importantly noted here:

a) All health care providers are responsible for documentation in the health record in accordance with legislative requirements, hospital policies and professional practice guidelines/standards.

b) The health record must be compiled in a timely manner and contain sufficient data to identify

the patient, support the diagnosis or reason for encounter, justify the treatment and accurately document the results.

c) All documentation in the health record must be complete, accurate and legible.

Inpatient Documentation: In-patient documentation requirements can be found in the Physician Chart Completion policy.

Outpatient Documentation:

a) The health record of an out-patient who visits the hospital solely for diagnostic procedures need only include the orders for the procedures, any consent to the procedures obtained in writing and a record of the procedures.

b) Other outpatients' health records will include: a note dictated/written for each visit and assessment times for the ED visits by the MRP or delegate containing documentation as outlined by the Public Hospitals Act.

Completion Requirements:

a) Chart completion requirement as outlined in the TDMH Chart Completion Policy must be completed no longer than fourteen days following discharge of the patient. The process for notifying physicians of charts that require completion and notices failure to complete patient records is outlined in the Chart Completion Policy.

IV. Orders

a) All orders for treatment shall be in writing and shall be signed or electronically authenticated by the MRP or delegate, except for orders as delegated under a medical directive. The MRP, or team member delegate, shall be responsible for the completion of all requisitions requiring clinical information. All such requisitions shall be completed as are necessary to ensure that all adequate work is completed.

V. Self-Discharge

a) When a patient insists upon leaving TDMH against the advice of the MRP the patient shall be warned of the consequences of doing so. If the MRP or delegate is present, a statement describing the circumstances shall be entered by the MRP or delegate in the patient's health record and the patient shall be asked to sign a release form. The MRP or delegate who writes the discharge order shall be responsible for the completion of the discharge summary.

VI. DelegatedMedical Acts

a) Refer to the delegation of medical acts policies for information regarding the procedure and process for the approval of a delegated controlled act:

b) The College of the Health Profession accepting the delegation must have approved this transfer of function by its registered members in Ontario. Executive Leaders (or their delegate) are responsible for ensuring the requirements of their respective disciplines regarding their Act are being met. For example, Executive Leader for Nursing must ensure that the requirements of the Nursing Act related to delegated controlled acts are followed.

c) All proposed delegated Medical Acts from Professional Staff members to other disciplines must be approved by Medical Advisory Committee. All proposed delegations from other disciplines must be approved by the Leader within TDMH who has accountability for Professional Practice Standards of that discipline, and be in accordance with the regulations of that College.

d) Responsibility for carrying out delegated controlled acts is jointly the responsibility of the health

professional delegating the act, the institution, the Program and its interdisciplinary team, as well as the individual accepting the delegation. It is the responsibility of the individual practitioner within the framework of a professional practice model to ensure his/her certification status is current, meeting the requirements of their professional College and the Regulated Health Professional Act (Health ProfessionsRegulatoryAdvisoryCouncil).

VII. Medical Directive

a) TDMH has specific procedures and processes outlined regarding the use of medical directives, protocols, and order sets. Professional Staff members who wish to enact a new medical directive, protocol and/or pre-printed order must abide by the guidelines and process for approval. Any medical directive shall be reviewed every two years and shall be approved by the Medical Advisory Committee.

D. SPECIALAREAS,PATIENTTYPESANDMEDICAL PROCEDURES

I. BloodTransfusions

a) The Blood Transfusion Committee shall ensure a Transfusion Manual is maintained and updated appropriately.

b) Members of the Professional Staff shall acquaint themselves and adhere to all policies and procedures regarding the prescribing and administration of all blood and/or blood products. All orders for blood products shall be in writing and signed by the MRP, or delegate.

II. Intensive Coronary Cardiac Care Unit

The Intensive Coronary Cardiac Care Unit (ICCU) shall be responsible for the care and treatment of patients known or suspected to have an unstable or potentially unstable cardiac disorder requiring monitoring under the supervision of an internal medicine physician.

III. EmergencyDepartment

a) Patients admitted through the Emergency Department will be cared for by their Family physician, or delegate, or if not so identified will be referred by the Emergency physician to the appropriate department. The physician designated by the patient for registering the patient in the Emergency Department may be required by the President and CEO, or by the Medical Advisory Committee to justify the basis of the registration of the patient in the Emergency Department.

c) A patient registered in the Emergency Department shall be the responsibility of:
   i) the attending physician in the Emergency Department; or
   ii) the Professional Staff member who has referred a patient to the Emergency Department and who has examined the patient prior to his/her being referred to the department and who has properly and adequately informed the department as to the nature of the case and the treatment required; or

d) Patients requiring dental consultations will be registered in the Emergency Department by a physician who is a member of the Professional Staff and designated by the patient. If no such designation is received from the patient, the patient will be registered in the Emergency Department by the staff emergency physician in consultation with the member of the Dental Staff designated by the patient, or if no such designation has occurred the patient will be referred by the emergency physician to a member of the Dental Staff, except in the case of oral maxillofacial surgeons who have admitting privileges.

e) All orders for therapy, and all clinical impressions and findings, x-ray results, diagnoses, referrals and discharge orders shall be entered in the health record of the patient and signed by the MRP or designate.

f) A registered patient shall not remain in the department for observation unless hospital beds are

unavailable and approved by the emergency physician, provided that a registered patient may remain in the department for observation if in the opinion of the staff emergency physician or the MRP, the condition of the patient warrants observation for less than 24 hours.

IV. LaboratoryMedicine

a) Members of the Professional Staff shall acquaint themselves and adhere to all rules, regulations, policies and procedures regarding the use of the various laboratory services.
   i) Information regarding available services can be found on the Tillsonburg District Memorial Hospital Intranet Site.
   (ii) All requests for laboratory tests must be signed on the patient's chart by a member of the Professional Staff or designate.

b) Most laboratory tests which are required for immediate diagnosis or treatment of a patient are performed by the Laboratory located on site and operates 24 hours per day, 7 days per week. Tests performed in other specialized laboratories are only available during regular working hours. Low volume and highly complex tests are referred out for testing and only performed at scheduled intervals. If there are specific reasons for obtaining the test results sooner, the appropriate laboratory should be contacted to determine the feasibility of performing the test more quickly.

c) Information regarding proper specimen collection, identification, handling and labelling requirements is available. Consult the SpecimenCollectionGuide (in progress) on the Hospital Intranet.

d) **Priority Categorization –** The Laboratories process and test specimens based on priority results:

- **STAT** requests are reserved for medical emergencies. Requests for "stat" work will result in the sample being processed and reported in such a way as to minimize turnaround time. In general, the testing is completed within 1 hour of the laboratory receiving the specimen. It may be necessary to contact the laboratory for more information, since the service offered depends not only on the type of test, but also on the time of day and days of restricted staffing. The misuse of STAT orders causes delays in testing for all areas.
- **ASAP** are for situations that are pressing, but are not emergencies – e.g. when wanting to discharge a patient prior to doctor's rounds etc. These tests are completed before routine tests usually within 2 hours.
- All other samples are considered routine.

e) Professional Staff may request the addition of new tests. New tests will be added to the test menu if they are proven to be of benefit to patient care and cost effective. Contact the Laboratory to request new test procedures and their benefits and costs.

f) Lab results for outpatients will only be given over the phone after suitable identification of the requesting physician. Test results for inpatients are posted and available for look up on *Powerchart* once verified.

g) Point of Care (POC) Testing must comply with the POCT policy, processes and procedures. POC testing results must be recorded in the patient's medical record and be clearly distinguished from the laboratory test results.

h) Critical values must be telephoned to the ordering physician or designate as soon as possible after completion of the test and must have a valid telephone number for the patient.

V. Long Stay Cases

a) An Alternate Level of Care patient is one who has finished the acute phase of his/her treatment but remains in the acute care bed usually awaiting placement in a complex continuing care unit, long term care home, rehabilitation facility, other extended care institution, home care program, etc." (Provincial Definition of Alternate Level of Care). This also includes patients awaiting transfer to facilities for continuing care, e.g. convalescent facilities, or patients unable to be discharged home because of housing, household, economic or other family circumstances.

b) Any patient at TDMH occupying an acute care bed while awaiting an alternate level of care (ALC) must be reported to the Ministry of Health through appropriate documentation on the health record.

c) The patient is classified and documented as "Alternate Level of Care" when the MRP or designate in consultation with the health care team indicates that a patient no longer requires acute care. The patient must be informed by the MRP or designate/ or a member of the health care team member that they no longer require acute care and have been designated ALC.

d) The Alternate Level of Care form will be initiated by any team member (i.e. nursing, social work, PT, OT, etc) and signed by the MRP or designate.

VI Medical Legal Cases

a) Professional Staff members shall acquaint themselves with the hospital policies and procedures to be followed in the management of all cases with medical-legal implications. In particular, Professional Staff members should be familiar with current legislations related to consent to treatment, substitute decision makers, personal health information protection, quality of care information protection, as well as any mandatory reporting situations, e.g. suspected child abuse, gun-shot wounds.

VII. Operating Room

a) It is the duty of all Professional Staff to keep knowledgeable of and observe fully the policies of the operating room.

b) Operating room, facilities and equipment shall not be used except strictly in accordance with the rules, regulations and policies established from time to time by the Surgical Advisory Committee with the approval of the Medical Advisory Committee and the Board.

d) There shall be established and maintained a Surgical Advisory Committee which shall have duties and accountabilities as delineated by the Medical Advisory Committee with representation as specified by the Medical Advisory Committee.

d) All operations shall be booked by the operating surgeon/dentist (or delegate) after seeing the patient, and not by the referring physician. In all unilateral procedures, the involved side is to be noted on the operative booking list and this information is also to be written on the patient's physician record form and on the authorization for medical and/or surgical treatment. Evening, night, Saturday, Sunday and holiday booking shall be emergency and urgent and shall be made through the Charge Nurse or delegate.

e) Each Department delineates procedural privileges outlining the scope of clinical practice granted to physicians appointed to the Professional Staff in accordance with the Professional Staff. Changes in operating room privileges shall require express consent from the chief of the department or division head, and must be in compliance with the specified operating room or surgical policy.

V. Surgery

a) While primarily responsible for histories, physical examinations and consultations is as stated in these rules and regulations, it is emphasized that the operating surgeon is ultimately responsible for

seeing the required records are on the patient's clinical chart before he/she commences surgery.

b) Except in extreme emergencies, the chart of every patient undergoing surgery shall, before surgery is commenced, contain diagnostic screening reports consistent with current pre-admit guidelines.

c) It is the responsibility of the operating surgeon performing surgery to ensure the aid of a qualified assistant or other physician is available to assist.

d) An individual will not be permitted
- To assist at surgery in any capacity unless credentialed and approved to do so by the President and CEO of the Hospital or delegate.

An individual will be permitted
- To observe or be present in the Operating Room consistent with the TDMH Observer Policy.

e) The operating surgeon must see the patient regularly during the post-operative period and shall record the patient's progress appropriately on the chart.

E. CLINICAL

I. Medications

a) The TDMH Formulary and Pharmacy are excellent resources to clinical staff as a resource for clinical care.

b) The Medical Advisory Committee, through the Pharmacy and Therapeutics Committee shall ensure the preparation, maintenance, and updating of a Hospital Drug formulary.

c) Members of the Professional Staff shall acquaint themselves and adhere to all rules, regulations, policies and procedures regarding the acquisition, prescribing, and administration of pharmaceuticals

d) A non-formulary drug request must be reviewed and approved by the Medical Advisory Committee. Non-formulary drugs are not routinely stocked in the pharmacy, and a delay of up to 48 hours is to be expected. The signed "non-formulary drug request form" is Pharmacy's authority to purchase the requested supply of medications for that specific patient. Usage of all non-formulary drugs will be reviewed by the respective Committees.

The following procedures should be noted:

a) Nursing care, diagnostic tests and medication orders for each patient shall be recorded on the approved institutional order form;

b) Medications shall be administered only upon the order of a Professional Staff member or their delegate, who has been assigned clinical privileges; or an individual who has been granted special prescribing privileges;

c) Telephone orders will comply with the TDMH Verbal Orders Policy

d) Each order must be clearly written, dated and signed by the prescriber in ink;

e) Surgery automatically cancels all orders. All medication orders must be completely re-written post-operatively (Note: "Resume Pre-Op Meds" is not legally acceptable);

f) Investigational Drugs include all drugs used in clinical trials (drug study) protocols regardless of whether they are standard of care, ancillary to the object of the study or the focus of the study. Drugs used in procedural studies which are not approved for such use are considered study drugs even though they are not the principle focus of the study. These may be:
   i) drugs not yet approved for general use;
   ii) Commercially available drugs being used in new dosage regimens, or for new indications;
   iii) Commercially available drugs being used in recognized doses and indications for the purpose of comparison with other available drugs or with new agents, or
   iv) investigational drugs for one time use, or
   v) drugs used in non-drug studies (e.g. procedural studies) which are not the normal standard of care.

g) Pharmacy must be notified of all suspected adverse drug reactions. "An adverse drug reaction is any undesirable clinical response which might be due to any drug(s) and which is considered to merit reporting." Pharmacy will report all suspected adverse drug reactions to the Pharmacy and Therapeutics Committee and Health Canada.

h) Pharmaceutical Representatives must obtain permission from the Pharmacy Director, or designate to detail their products to Hospital Staff.

II. Bed Management

Members of the Professional Staff shall comply with the approved TDMH Bed Management Process.

III. Infection Prevention and Control/Occupational Health

a) All Professional Staff shall comply with TDMH Infection Prevention and Control policies and practices. It is the accountability of all Professional Staff members to familiarize themselves with these policies.

b) All Professional Staff shall comply with the Occupational Health and Safety Standards, policy and education. It is the accountability of all Professional Staff members to familiarize themselves with these policies and meet the requirements of Occupational Health Standards as required.

IV. End of Life & Resuscitation Process & Procedures

a) Regulated Health Care Professionals involved in the care of a patient are responsible for knowing the resuscitation plan and end of life decisions of the patient and communicating the plan to other members of the health care team.

F. MEDICAL COVERAGE

I. Procedural Privileges

a) Each member of the Professional Staff shall be assigned a particular privilege category that will delineate the extent of the Professional Staff member's privileges.

b) All Professional Staff must be aware and adhere to their departmental delineation of privileges.

c) Any change in privileges requested by a Professional Staff member must be supported by the Chief of Staff and the Head of the relevant department.

d) Any changes in privileges must be in compliance with the medical department requirements, particularly with regard to enhancement of privileges, and other relevant Hospital policies in accordance with the Professional Staff By-Laws of the Hospital.

e) Each department shall make recommendations through the Credentials Committee, which has authority to accept/recommend changes to the Medical Advisory Committee, on the clinical procedures to be performed in each department that are outside the normal scope of training/experience for the members of the department/division.

f) Under normal circumstances, any Professional Staff member who has a significant practice change such as a sudden reduction in clinical volume or alteration in case-mix must explain to the Medical Advisory Committee the reasons for such a change.

II. Vacations/LeaveofAbsence

a) A plan during practice absences shall be developed by the Professional Staff member and by each department to ensure appropriate medical coverage and continued functioning of the Hospital during those times of absence.

III. AbuseofHospitalPrivileges

a) When a member of the Professional Staff is attempting to exceed his/her privileges or is incapable of providing a service that he/she is about to undertake, this shall be communicated immediately to the Chief of Staff and/or President and CEO of TDMH or delegate.

b) Upon being informed of a Professional Staff member potentially exceeding his/her privileges, the Chief of Staff and/or President and CEO of TDMH or delegate, may, at his/her discretion, prevent such procedures from taking place until such time as an investigation has taken place.

c) An investigation shall be undertaken for all such incidents by the Head of the relevant department in consultation with the Chief of Staff and will be dealt with by the chiefs of the departments according to their function as defined in the Professional Staff By-Laws and Public Hospitals Act.

IV. Medical&Non-MedicalObservers

a) A member of the Professional Staff may request to have an observer accompany them while in TDMH. Refer to the TDMH Observer Policy for detailed information related to the responsibilities of the Professional Staff member (who acts as the Sponsor) and the Observer.
b) An Observer is not permitted, in any circumstances, to provide any patient care.

V. WithdrawalofMedicalServices

a) Whenever there is a threatened withdrawal of services by a department or departments of the Professional Staff, the following steps will be taken:
   i) the Chief of Staff/Chair of the Medical Advisory Committee, will call an emergency Medical Advisory Committee meeting;
   ii) at this meeting the implications of any service withdrawals will be discussed and the appropriate action taken to minimize patient cancellations and service disruption and ensure overall patient safety;
   iii) the Medical Advisory Committee, in its function of overall supervision of professional care, will continue to function during any service or threatened service withdrawal and it will effectively keep the President and CEO of TDMH and the Board of Directors updated on the implications of any service withdrawal;
   iv) all reasonable attempts will be made to maintain the quality of medical care at a satisfactory level for all in-hospital patients and those utilizing the emergency and out-patient services.

G. ADMINISTRATIVE

I. EvaluationofProfessionalStaff

a) On an annual basis, each member of the Professional Staff shall be reviewed by the Head or delegate

of the department regarding recommendation for reappointment to the Professional Staff as set out in the Professional Staff by-laws.

II. Professional Code of Conduct

1. Ethics/Business Conduct

a) All Professional Staff working within TDMH shall abide by the ethical policies/guidelines.
   (i) All Professional Staff working within TDMH shall abide by the TDMH Code of Conduct and recognize how to address ethical issues.
   (ii) All Professional Staff working within TDMH shall abide by the TDMH Ethical Guidelines.

b) Ethical policies and guidelines are inclusive of a number of areas where code of conduct and appropriate behaviours are expected and understood. Please refer to the TDMH Workplace Harassment Policy.

2. Managing Complaints

a) In order to register a complaint against a member of the Professional Staff all complaints should be in writing, signed by the complainant and shall state clearly the nature of the complaint. Complaints registered by telephone to TDMH will be recorded in writing by TDMH Administration.

b In general, complaints shall be referred to Administration at TDMH, except those outlined in the Professional Staff By-Laws.

III. Departmental and Committee Responsibilities

a) Practice requirements as established by each individual department must be met in order to maintain membership in a department. This may include such things as: on call, service to emergency, or time commitment to practice in the community.

b) All Professional Staff may be required at the request of the Medical Advisory Committee, the Professional Staff Organization, or Hospital Administration to be involved in TDMH Committee activities.

IV. Medical Department Review

a) Medical department reviews will be conducted at the discretion of the Medical Advisory Committee in consultation with the Head of the Department and the Chief of Staff

b) These reviews may encompass several components and will include any, or all, of the Senior Administration Group depending on the component being reviewed.

c) Each department Head will be required to report as required by the Medical Advisory Committee to the Medical Advisory Committee regarding activities, initiatives and issues of the particular medical department.

d) As part of TDMH's overall operational planning process, departments will work in conjunction with TDMH departments to develop short and long term goals regarding quality, operations, manpower plans, and capital requirements.

V. Limiting Professional Staff Appointments

a) The Board of TDMH may restrict or deny the appointment of Professional Staff members to any department of TDMH either entirely or to certain categories, further s.44 of the Public Hospitals Act and the Professional By-Laws of the Hospital. The Medical Advisory Committee, in response to Board policies, the Professional Staff Rules and Regulations, medical manpower plans and any

other relevant Hospital policy and procedures, may recommend to the Board limitations on Professional Staff appointments under circumstances consistent with the Professional Staff By-Laws.

b) Proposed limitations to Professional Staff privileges will be initiated through the Chief of Staff to the Medical Advisory Committee. The Medical Advisory Committee will consider the rationale of any such proposed limitations and will make recommendations to the Board.

VI. Appointments to the Professional Staff

a) Each application for appointment shall be in accordance with the TDMH Professional Staff By-Laws.

VII. Reappointments

a) Each application for reappointment shall be in accordance with the TDMH Professional Staff By-Laws.

VIII. Appointment of Heads of Department

a) Appointment of Heads of Department shall be in accordance with the TDMH Professional Staff By-Laws.

H. PATIENT RIGHTS AND RESPONSIBILITIES

I. Patient Rights, Dignity and Independence

a) TDMH believes in and encourages a partnership between patients and their health care providers. Each patient's role as a member of this partnership is to understand and exercise his/her rights and responsibilities. A commitment to ensuring patient involvement in decision making, access to therapies of choice and accountability to providing a safe environment for patients, visitors and hospital staff is essential. TDMH has developed guidelines and policies to support these principles. All members of the Professional Staff should be familiar with these policies and guidelines.

b) The privacy and confidentiality of all patients/clients will be protected. TDMH has consistent policies that provide direction to Professional Staff on privacy and confidentiality issues. Professional Staff can utilize the Privacy Office as a resource for privacy and confidentiality issues and must contact the Privacy Office if patients' personal health information is compromised, i.e. lost, stolen or accessed without authority. Refer to the TDMH website for policies and guidelines related to privacy and confidentiality.

II. AMENDMENTS

a. From time to time, and consistent with the By-Laws of the Hospital, the Medical Advisory Committee may recommend to the Board amendments to the Professional Staff Rules and Regulations for approval.

b. Such amendments, when so enacted or necessitated by other changes to titles, staffing, governance or organization within TDMH shall form part of the Rules & Regulations as a whole. This includes non-substantive changes and amendments as are reasonably required for consistency, accuracy and ease of reference.