



MEDICAL STAFF RULES

FRASER HEALTH AUTHORITY

MAY 16, 2013

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PREAMBLE

The following document comprises the Medical Staff Rules (“Rules”) pursuant to the Medical Staff Bylaws (“Bylaws”) of the Fraser Health Authority (hereinafter referred to as the “FHA or FH”). These Rules outline Medical Staff and FHA obligations in respect of patient care. This care shall be consistent with a contemporary standard of care.

The Rules are applicable to all members of the Medical Staff practicing in FHA facilities. Regional Departments are organized to facilitate clinical service delivery.

The Rules apply to all members of the Medical Staff. Policies governing medical staff practice within Regional Departments are developed by the Regional Departments at the local and/or regional level. Individual facilities may have policies/procedures governing aspects of Medical Staff practice which are specific to the facility. Similarly, Regional Departments will have policies that are specific to Medical Staff practice in the Regional Department. In those cases, the facility or Regional Department policies are subsidiary to the Rules. In the event of conflict or contradiction between the Rules or the Bylaws and subsidiary Medical Staff policies of a facility or Regional Department, the Bylaws and Rules will prevail.

Gender specific words apply equally to both genders. Singular and plural terms include both as the context implies. Similarly, the use, or lack of use, of capital letters does not change the interpretation of words which are specifically defined in this document.

The Board of Directors is ultimately accountable for the quality of care and provision of appropriate resources in the facilities and programs operated by the Health Authority. This accountability is delivered via the Chief Executive Officer (CEO) who is the Board of Directors’ representative as outlined in the Hospital Act Regulation section 3.

AUTHORITY TO PROPAGATE AND AMEND THE RULES

The Medical Staff Bylaws are not in force until approved by the Minister of Health Services. Rules do not require the Minister’s approval.

The Board has the authority to approve the Rules on the recommendation of the FHA’s HAMAC. Revisions to the Rules will be made periodically to ensure the Rules reflect contemporary organization of the Medical Staff as well as to ensure Medical Staff practices are in accordance with current standards of care.

EFFECT OF COPY OF THE RULES

Once approved by the Board, a copy of these Rules shall be sent to all members of the Medical Staff, after which, all members shall be deemed to be conversant with them. A copy of the most recent approved revision of these Rules signed by the Chair of the FHA’s Board and the Chair of HAMAC may be given in evidence without any further proof of authenticity.

PURPOSE OF THE MEDICAL STAFF ORGANIZATION

In addition to the general purpose outlined in the Bylaws, the purpose of the Medical Staff organization is to apply the regulatory authority of the Board to all members of the medical, dental, midwifery, nurse practitioner and allied health professions who are granted permits by

the Board to practice their disciplines within FHA, and to maintain and support the rights and privileges of the Medical Staff as provided herein.

The objective is to ensure FHA provides high quality patient care, education of medical, dental, midwifery, nurse practitioner and allied health professionals and research in the health disciplines.

The organization allows the Medical Staff to provide advice to the Board in order to achieve the mission, vision, values and strategic directions of FHA. The organizational structure is depicted in Appendix 1.

ARTICLE 1 – DEFINITIONS

Affiliation Agreement: An agreement between the Board of Directors of FHA and the Board of Governors of a post-secondary educational institution.

Appointment: The process by which a Physician, Dentist, Midwife or Nurse Practitioner becomes a Member of the Medical Staff of the FHA. Appointment does not constitute employment.

Board: The Board of Directors of the FHA which is the governing body of the FHA.

Chief Executive Officer (CEO) / President: The person engaged by the FHA to provide leadership to the FHA. This individual is responsible for management of the Hospitals and other facilities and Programs operated by the FHA in accordance with the bylaws, rules and policies of the FHA.

Clinical Fellow: A Physician, Dentist, Midwife or Nurse Practitioner temporarily attached to facilities and Programs operated by the FHA for the purpose of postgraduate training in accordance with an Affiliation Agreement.

Clinical Trainee: A member of the Medical Staff temporarily attached to the FHA for the educational purpose of gaining additional experience or training.

Consultant: A Member of the Medical Staff who has been asked to evaluate a patient and provide recommendations for care (consultation only), write orders for care and follow up (consultation with ongoing care) or assume the entire care of the patient and become the Most Responsible Practitioner (consultation with transfer of care).

Credentials: Refers to the qualifications, professional education and training, clinical experience and experience in leadership, research, education, communication and teamwork that contribute to the Medical Staff member's competence, performance and professional suitability to provide safe, high quality healthcare services.

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

Designate: A Member of Medical Staff who has the appropriate credentials and privileges afforded to them by the Bylaws or is an Intern, Resident, Clinical Fellow/Trainee under the direct supervision of the Most Responsible Practitioner.

Evidence Act: The Evidence Act, [RSBC 1996] Ch. 124, as amended or replaced from time to time.

Executive Director: The senior administrative leader appointed by FHA and accountable to the VP Clinical Operations to oversee operations of assigned facilities and co-manage, with the Program Medical Director, assigned Programs.

Executive Medical Director: The Physician, appointed by FHA and accountable to the VP Medicine, to provide professional leadership for co-ordination and direction of medical care within a group of Programs.

Facility: A health care facility operated by FHA.

FOIPPA: The Freedom of Information and Protection of Privacy Act, [RSBC 1996] Ch. 165, as amended or replaced from time to time.

Head of Department (local): The Member of the medical staff in each facility or community program where the Regional Department operates, appointed by the Board and responsible to the Regional Department Head. The Head of Department (local) is responsible for coordinating functions of the regional department in that facility and will be a member of the Multidisciplinary Healthcare Coordinating Committee

Health Authority Medical Advisory Committee (HAMAC): The advisory committee to the Board on medical, dental, midwifery and nurse practitioner matters, as described in Article 8 of the Bylaws.

Health Professions Act: The Health Professions Act, [RSBC 1996] Ch. 163, as amended or replaced from time to time.

Hospital Medical Coordinator: The Member appointed by the Board and responsible to the Executive Director. The Hospital Medical Coordinator is responsible to coordinate activities of Members at facilities and to co-chair the Multidisciplinary Healthcare Coordinating Committee.

Hospital Act and Regulation: The Hospital Act, [RSBC 1996] Ch. 200 and associated Regulation, as amended or replaced from time to time.

Human Tissue Gift Act: The Human Gift Act, [RSBC 1996] Ch. 211, as amended and replaced from time to time.

Locum Tenens: The Medical Staff Category to which a practitioner is appointed when replacing an existing Medical Staff member or fulfilling the duties of a Medical staff vacancy for a limited time.

Medical Care: For the purposes of this document, Medical Care includes the clinical services provided by Physicians, Dentists, Midwives and, Nurse Practitioners.

Medical Staff: The physicians, dentists, midwives and nurse practitioners who have been granted privileges by the Board to practise in the facilities and Programs owned or operated by the FHA.

Medical Staff Association: The organization established pursuant to Article 7 of the Bylaws.

Medical Staff Bylaws (Bylaws): The Bylaws promulgated by the Board pursuant to the Authority of the Hospital Act governing the relationship and responsibilities between the Board and Medical Staff, and the organization and conditions of practice of the Medical Staff in the facilities and Programs owned or operated by FHA.

Medical Staff Rules (Rules): The Rules approved by the Board governing the day-to-day obligations of the Medical Staff in the facilities and Programs owned or operated by FHA.

Medical Students: Undergraduate medical students attached to the FHA for the educational purpose of gaining practical clinical experience during a specified rotation administered by the University in which they are registered.

Member: A Physician, Dentist, Midwife or Nurse Practitioner appointed to the Medical Staff of FHA.

Midwife: A Member who is duly licensed by the College of Midwives of British Columbia and who is entitled to practice midwifery in British Columbia.

Most Responsible Practitioner (MRP): The Physician, Midwife, Nurse Practitioner or Oral/Maxillofacial Dental Surgeon who is a Member of Medical Staff and has the overall responsibility for the management and co-ordination of care of the patient at any given time.

Multidisciplinary Healthcare Coordinating Committee (MHCC): A committee with representation from medical, nursing and allied health professional staff at a facility or Community Program which functions to co-ordinate the delivery of health care in that facility or community program.

Nurse Practitioner: A member of the medical staff or a person given permission to practice as a non-employed allied health professional who is duly registered as a Nurse Practitioner with the College of Registered Nurses of British Columbia.

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

Physician: A Member who is duly licensed by the College of Physicians and Surgeons of British Columbia and who is entitled to practice medicine in British Columbia.

Practitioner: A duly qualified licensee in good standing of the College of Physicians and Surgeons of BC, the College of Dental Surgeons of BC, the College of Midwives, or College of Registered Nurses of British Columbia of BC who is not a Member.

President of Medical Staff: The representative of the Medical Staff elected as an officer of the Medical Staff Association to advocate for individual or group Medical Staff interests.

Primary Regional Department: The Regional Department to which a Member is appointed according to his/her training, and within which the Member delivers the majority of care to patients.

Privileges: The right granted by the Board to Members to provide specific types of medical care within the facilities and programs of the Health Authority. Privileges are differentiated into:

- **Core Privileges:** Those activities or procedures which are permitted by virtue of possessing a defined set of credentials usually obtained as part of a standard training program.
- **Non-Core Privileges:** Those activities and procedures which are outside of the core privileges, that require specific training or certification or reflect advances in medical practice not currently reflected in core privileges.

Program: An ongoing care delivery system under the jurisdiction of FHA for coordinating a specified type of patient care.

Program Medical Director: The Member appointed by FHA and accountable to the VP Clinical Operations, with professional accountability to the VP Medicine, to be in charge of and responsible for the operation of and quality of care within a Program. For the purpose of these Rules a Program Medical Director may be the Regional Department Head for a Program consisting of a single Regional Department

Regional Department: A major subunit of the Medical Staff composed of members with common clinical or specialty interest.

Regional Department Head: The Member accountable to the Program Medical Director and responsible for the operation of and quality of care within a Regional Department. For the purpose of these Rules a Program Medical Director may be the Regional Department Head for a Program consisting of a single Regional Department.

Regional Division: A component of a Regional Department composed of members with a clearly defined sub-specialty interest.

Regional Division Head: The Member appointed by the Board and responsible to the Regional Department Head. The Regional Division head is responsible for co-ordinating the operation of and quality of care within a Regional Division.

Regulation: The Regulation made under the authority of the Hospital Act.

Resident: means a Physician or Dentist temporarily working in the facilities operated by FHA for the purpose of postgraduate training in medicine or dentistry in accordance with an Affiliation Agreement.

Signature: An authentic signature and/or electronic sign off.

Specialist: A physician with “Fellowship” or “Certificate” status with the Royal College of Physicians and Surgeons of Canada or equivalent, or relevant clinical experience and licensed to practice as a Specialist by the College of Physicians and Surgeons of British Columbia.

Vice President Medicine: The Physician, appointed by the CEO, responsible for the coordination and direction of the activities of the Medical Staff.

Vital Statistics Act: The Vital Statistics Act, [RSBC 1996] Ch. 479, as amended or replaced from time to time.

Year: The fiscal year adopted by the FHA, defined currently as April 1 of a given year to March 31 of the following year.

ARTICLE 2 – ORGANIZATION OF THE MEDICAL STAFF

In accordance with Article 7 of the FHA Bylaws, the Board, upon the recommendation of HAMAC, shall organize the Medical Staff into Regional Departments and Regional Divisions as deemed appropriate to meet the needs of the FHA.

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

- engagement in quality improvement, quality assurance and peer review
- strategic medical staff resource planning
- promotion of professional development and continuing medical education
- the support of the Medical Staff through specific processes to promote Member well being

Members' well-being will be a focus of each Regional Department and the Regional Department Heads will work with the Vice President Medicine and Executive Medical Directors to:

- promote health and wellness amongst Members
- encourage a healthy, respectful workplace
- establish mechanisms to identify Members at risk of mental illness, substance dependency or severe professional fatigue
- develop strategies and supports for timely respectful intervention for medical professionals with compromised health and well-being
- support the Medical Staff through development of specific programs to promote Member well-being
- establish mechanisms to report impaired Members, to ensure that such Members promptly cease practice and to allow recovering Members to resume patient care responsibilities

2.1 HEALTH AUTHORITY MEDICAL ADVISORY COMMITTEE

2.1.1 The Health Authority Medical Advisory Committee (HAMAC) is appointed by the Board of Directors and makes recommendations to the Board of Directors with respect to cancellation, suspension, restriction, non-renewal, or maintenance of the appointments and privileges of all members of the medical staff to practice within the facilities and programs operated by the FHA.

2.1.2 The HAMAC provides advice to the Board of Directors and to the CEO on:

- 2.1.2.1 the provision of medical care within the facilities and programs operated by the FHA
- 2.1.2.2 the monitoring of the quality and effectiveness of medical care provided within the facilities and programs operated by the FHA
- 2.1.2.3 the adequacy of medical staff resources
- 2.1.2.4 the continuing education of the members of the medical staff
- 2.1.2.5 planning goals for meeting the medical care needs of the population served by the FHA

- 2.1.2.6 the availability and adequacy of resources to provide appropriate patient care in the FHA

2.2 MEMBERSHIP OF HAMAC

- 2.2.1 The membership of HAMAC shall include:
- Regional Department Heads
 - Hospital Medical Coordinators
 - Program Medical Directors
 - Three (3) Presidents of the Medical Staff Associations who have been elected by the medical staff of the Health Authority
 - The Chief Medical Health Officer of the Health Authority
 - The Vice President Medicine of the Health Authority, who shall provide secretariat services to the HAMAC
 - The CEO of the Health Authority, who shall be a non-voting member
 - Other senior administrative or medical staff of the Health Authority as appropriate, in a non-voting capacity
- 2.2.2 The Chair and Vice-Chair of the HAMAC are appointed by the Board of Directors upon the recommendation of the HAMAC
- 2.2.3 The Chair and Vice-Chair will be selected from among the members of the Active Medical Staff.
- 2.2.4 The Chair of the HAMAC is appointed for a term of not more than three years and may be reappointed for up to three consecutive terms.
- 2.2.5 The Chair or Vice-Chair of HAMAC shall provide a report to the Board of Directors and to the CEO on a regular basis. The Chair or Vice-Chair of HAMAC shall attend meetings of the Board of Directors and the appropriate committee of the Board to participate in discussion pertaining to the purposes identified for the HAMAC under Article 8.1 of the Bylaws.

2.3 DUTIES OF HAMAC

- 2.3.1 The purpose, duties and composition of the HAMAC are delineated in the Bylaws.
- 2.3.2 The list of Standing Committees shall be reviewed annually by the HAMAC and recommendations for revision shall be presented to the Board as necessary.
- 2.3.3 Each Standing Committee shall review its Terms of Reference annually and make recommendations to the HAMAC for changes, if any. The Terms of Reference of a Standing Committee shall not be effective until approved by the Board.
- 2.3.4 In addition to these Standing Committees, HAMAC may recommend to the Board the formation of additional committees as it deems necessary.

2.4 REGIONAL DEPARTMENTS

Regional Departments will usually be structured as FHA-wide departments. Regional Departments will usually be structured to reflect established service delivery patterns between facilities amongst Members with common clinical or specialty interest, often in support of clinical care or on-call responsibilities. All Members shall be appointed to at least one Regional Department.

- 2.4.1 Where a clinical program consists of a single Regional Department that Program is considered to be synonymous with the Regional Department and the Program Medical Director will fulfill the functions of the Regional Department Head.
- 2.4.2 Individual Regional Departments may be further organized into Divisions of clearly defined (sub) specialty interests or specific clinical programs and some Divisions may have a relationship with more than one Regional Department or Program.
- 2.4.3 Regional Departments will select a Head of Department (local) for every facility in which that Regional Department has Members. The Head of Department (local) of each facility will be part of the Multidisciplinary Healthcare Coordinating Committee for that facility.
- 2.4.4 Members will be appointed to a Primary Regional Department based on the specialty and/or majority of their clinical practice.
- 2.4.5 In order to fulfill the Regional Department mandate, a Regional Department shall only be formed when it has a minimum of seven members of the Active or Provisional Medical Staff for whom the Regional Department is their Primary Regional Department.
 - 2.4.5.1 In the event that a Regional Department temporarily or permanently loses members such that its membership of Active or Provisional Members is less than seven, the Regional Department shall be reorganized within a larger Regional Department of similar clinical specialties on a temporary or permanent basis as applicable. In some circumstances, a Division within the Regional Department may be created.
- 2.4.6 Formation of a new Regional Department must be recommended by HAMAC to the Board for approval.

2.5 REGIONAL DEPARTMENT MEETINGS

All meetings shall be conducted according to Robert's Rules of Order, newly revised. Records of all meetings shall be kept.

- 2.5.1 Each Regional Department without Regional Divisions shall meet at least four (4) times a year and more frequently if required to conduct its administrative affairs, clinical appraisals, teaching if applicable, and service commitments. Regional Departments may hold a series of Regional Departmental meetings based in the various geographical areas.

- 2.5.2 Each Regional Department with Regional Divisions shall meet at least annually and more frequently if required to conduct its administrative affairs, clinical appraisals, teaching if applicable, and service commitments.
- 2.5.3 The Regional Department Meetings shall include:
- discussion of matters concerning the appropriate supply of Members, appointments, quality of medical care, education and discipline
 - discussion of the planned and efficient use of FHA resources in the Regional Department
 - morbidity and mortality case reviews
- 2.5.4 The voting on all motions shall be by a show of hands or by secret ballot if ordered by the Regional Department Head or, if requested, by a majority of those present. In case of a tie, the presiding officer shall have the deciding vote.
- 2.5.5 Minutes shall be kept of each meeting and shall include a record of attendance. The minutes of each meeting shall be submitted to the Program Medical Director and HAMAC. A summary of the minutes will form part of the regular professional reporting of the Program Medical Director to the Executive Medical Directors and the Vice President Medicine. Members of the Regional Department will receive a copy of the minutes and the summary.
- 2.5.6 Notice of meetings shall be given to all Regional Department members and to ex officio members.
- 2.5.7 Attendance at Regional Department meetings may be in person or by video or teleconferencing.
- 2.5.8 Meetings will occur at a facility.
- 2.5.9 The HAMAC Chair, the Vice President Medicine or delegate, and the President of the Medical Staff shall receive notice of and may attend Regional Department meetings as non-voting participants.
- 2.5.10 Regional Departments are encouraged to hold at least one in person meeting per year.
- 2.5.11 Attendance
- 2.5.11.1 Provisional Staff Members shall attend at least 50% of their Primary Regional Department or Regional Division meetings in a calendar year, unless excused by the Regional Department Head for just cause.
 - 2.5.11.2 Active Staff Members shall attend at least 50% of their Primary Regional Department or Regional Division meetings in a calendar year, unless excused by the Regional Department Head for just cause. HAMAC will be notified of all exceptions and excusals.
- 2.5.12 Quorum
- 2.5.12.1 A quorum for Regional Department meetings shall be determined by the Regional Department and approved by the HAMAC.

2.5.12.2 In addition to committees contained in this article, HAMAC may recommend to the Board the appointment of additional committees as it deems necessary.

2.6 REGIONAL DEPARTMENT POLICIES AND PROCEDURES

Subject to Article 2.6.2, each Regional Department, in consultation with its members, shall develop policies and procedures outlining the practice expectations and commitments of Regional Department members. These policies and procedures shall be reviewed and amended by the members of the Regional Department regularly. Initial approval and subsequent implementation of Regional Department policies and procedures shall be subject to review by HAMAC.

- 2.6.1 Regional Department policies and procedures shall, at a minimum, describe Regional Department members' responsibilities and commitments with respect to:
- on call coverage
 - adherence to corporate and clinical policies
 - continuing professional education
 - participation in Regional Department activities such as teaching rounds or quality improvement activities
 - participation on Regional Departmental sub-committees
- 2.6.2 Regional Department decisions regarding policies and procedures of the Regional Department shall require the support of a simple majority of eligible Regional Department members for acceptance.
- 2.6.2.1 All members of the Regional Department, irrespective of whether it is the Primary Regional Department in which they are a Member or an additional Regional Department in which they hold membership, are eligible to vote at Regional Department meetings, unless they are ineligible to vote by the category of their membership on the Medical Staff.
- 2.6.3 Regional Department policies and procedures that are facility based shall be reviewed by Multidisciplinary Healthcare Coordinating Committees, approved by HAMAC and be signed off by the Vice President Medicine (or delegate).
- 2.6.3.1 Facility based policies and procedures may be implemented after review by Multidisciplinary Healthcare Coordinating Committees.
- 2.6.3.2 Within 3 months facility based policies must be reviewed by the Regional Department and approved by HAMAC and signed off by the Vice President Medicine or rescinded.
- 2.6.3.3 Where a possible and appropriate the Regional Department shall begin efforts to generalize such facility based policies.

2.7 MONITORING QUALITY OF PATIENT CARE

- 2.7.1 Regional Departments shall be responsible for monitoring the quality of patient care provided by their members.
- 2.7.2 Regional Departments shall participate in a program of professional practice evaluation and structured quality improvement (where appropriate, this should be externally accredited) regarding the care provided to patients by its members which shall at a minimum include reviews of:
- patient clinical outcomes
 - adverse clinical events arising from patient care (harmful or near-harmful)
 - morbidity and mortality
 - mechanisms of care provision
- 2.7.3 The Regional Department Head is responsible for the development of and member participation in a quality improvement program.
- 2.7.4 Quality improvement activities of the Regional Department shall be performed strictly in accordance with the requirements of Section 51 of the Evidence Act.
- 2.7.5 The results of all Regional Departmental quality improvement activities shall be reported to HAMAC.
- 2.7.6 The specific quality improvement activities of the Regional Department will be described in further detail in the Regional Department policies and procedures.

2.8 REGIONAL DEPARTMENT HEAD

- 2.8.1 Each Regional Department Head shall be an Active Staff Member for whom the Regional Department is the Member's Primary Regional Department, and who shall be appointed by the Board upon recommendation of HAMAC.
- 2.8.2 The Regional Department Head shall report to and be accountable to the VP Clinical Operations via the Program Medical Director, and be professionally accountable to the Vice President Medicine via the Executive Medical Director and Program Medical Director for the activities of the Regional Department and its members.
- 2.8.3 All Members with membership in a Regional Department are eligible to hold the position of Regional Department Head.
- 2.8.4 The Regional Department Head will be remunerated for services as the Regional Department Head at a rate agreed to by the FHA.
- 2.8.5 Appointment as Regional Department Head and remuneration for the position shall be detailed in a contract outlining the role description, position responsibilities, objectives of the role and accountabilities.
- 2.8.6 The term of appointment for each Regional Department Head shall be three years, renewable by the Board upon recommendation by the VP Clinical Operations and Vice President Medicine and approval by HAMAC.

- 2.8.7 In recommending re-appointment of a Regional Department Head to HAMAC and the Board, the VP Clinical Operations and Vice President Medicine shall consider the results of annual performance reviews.
- 2.8.8 The review process for Regional Department Heads shall be contained in a contract.

2.9 RESPONSIBILITIES OF THE REGIONAL DEPARTMENT HEAD

- 2.9.1 In addition to those responsibilities defined in the Bylaws, responsibilities of the Regional Department Head shall include (but not be limited to):
- developing annual operating objectives for the Regional Department
 - functioning as the channel of communication to and from the Regional Department to keep members of the Regional Department informed regarding FHA, HAMAC and Departmental objectives, policies and general activities
 - maintaining a high degree of visibility by regular visits to each facility in which the regional department is active
 - serving as a member of the HAMAC
 - in collaboration with the HAMAC, recommending appointment of practitioners, renewal of Medical Staff membership and privileges.
 - in collaboration with the HAMAC, recommending appointment of Clinical Fellows and Clinical Trainees
 - authorizing temporary appointment and temporary privileges
 - developing, with the members of the Regional Department, standards of clinical practice for the Department and ensuring that the Department members work within established standards
 - ensuring that programs for the continuing medical education of Regional Department members are established
 - establishing a quality assurance/quality improvement structure and program for the Regional Department, which carries out the functions of review, evaluation and analysis of the quality of Medical Care and utilization of FHA resources
 - monitoring and evaluating the utilization of FHA resources by members of the Regional Department in order to ensure effective and efficient use of these resources
 - arranging and chairing Regional Departmental meetings as required in these Rules
 - if applicable, working with Universities to ensure that education programs and research activities are being sufficiently promoted and supported

- assisting in the development and maintenance of specific job descriptions for each Regional Division Head in the Regional Department
- advising the HAMAC regarding appointment of Division Heads
- promoting health and wellness amongst Members
- encouraging a healthy, respectful workplace
- investigating complaints regarding care provided by Regional Department members
- considering and making recommendations regarding all applications for leave of absence by Regional Department members
- reviewing with the Regional Department and the Program Medical Director and/or Vice President Medicine, the manpower requirements of the Regional Department and recommending a plan for the Regional Department
- contributing to the search and selection of applicants for vacancies in the Regional Department
- conveying the advice, opinions and duly passed motions of Regional Department members to the FHA and the HAMAC and relevant information from the FHA and HAMAC to the members of the Regional Department

2.10 SELECTION PROCESS FOR REGIONAL DEPARTMENT HEADS

- 2.10.1 Where a vacancy exists or following a resignation in the position of Regional Department Head, a search for a Regional Department Head shall be conducted.
- 2.10.2 The search for a Regional Department Head shall be undertaken by a duly appointed Search and Selection Committee.
- 2.10.2.1 For Regional Department Heads, the Search and Selection Committee will be established by and include the relevant Program Medical Director and shall include all the Heads of Department (local) for the Regional Department that is the subject of the Regional department Head application and at least four (4) of them shall be present for interview, the Vice President Medicine or delegate, two representatives from the relevant clinical Program appointed by the relevant VP Clinical Operations plus others as determined necessary and appropriate by the described members, including those necessary in order to comply with a relevant Affiliation Agreement.
- 2.10.2.2 The Members of the Regional Department may suggest relevant names for consideration by the search and selection committee.
- 2.10.2.3 The process used by the Search and Selection Committee shall comply with relevant corporate policies in force at FHA.

- 2.10.3 The Program Medical Director shall forward the recommendation of the Search and Selection Committee for a Regional Department Head candidate, who is supported by the majority of Heads of Department (local), to HAMAC.
- 2.10.4 HAMAC shall review the recommendation of the Search and Selection Committee and, if in agreement, recommend to the Board the appointment of the Regional Department Head candidate.

2.11 SUSPENSION OR TERMINATION OF REGIONAL DEPARTMENT HEADS

- 2.11.1 The Board may, on the recommendation of the FHA HAMAC, Vice President Medicine, VP Clinical Operations and/or CEO, suspend or terminate the appointment of any Regional Department Head. Prior to such suspension or termination notice shall be given in accordance with a relevant contract and HAMAC members shall be notified.
- 2.11.2 Suspension or termination of an appointment as Regional Department Head does not affect appointment to the medical staff of privileges.

2.12 REGIONAL DIVISIONS

Regional Divisions will usually be structured as FHA-wide divisions where the Regional Departments are large and multi-specialty. Regional Divisions may be structured to reflect established service delivery patterns between facilities amongst Medical Staff members with common clinical or specialty interest, often in support of clinical care or on-call responsibilities.

- 2.12.1 Regional Divisions may be created with a minimum of three Members with similar sub-specialty interests..
 - 2.12.1.1 In the event that a Regional Division loses a member(s) such that there is a single remaining member, the Regional Division shall be suspended or eliminated on a temporary or permanent basis, based on the recommendation of HAMAC.
 - 2.12.1.2 In the event that a Regional Division is temporarily or permanently suspended or eliminated, the remaining member(s) shall continue to be members of the Regional Department and the suspension or elimination of the Regional Division shall not be prejudicial to their ongoing membership on the Medical Staff as a Member of that Regional Department.

2.13 REGIONAL DIVISION MEETINGS

All meetings shall be conducted according to Robert's Rules of Order, newly revised. Records of all meetings shall be kept.

- 2.13.1 Each Regional Division shall meet at least four (4) times a year and more frequently if required to conduct its administrative affairs, clinical appraisals, teaching if applicable, and service commitments.
- 2.13.2 The Regional Division Meetings shall include:

- discussion of matters concerning the appropriate supply of members of the Medical Staff, appointments, quality of medical care, education and discipline
 - discussion of the planned and efficient use of FHA resources in the Regional Department
 - morbidity and mortality case reviews
- 2.13.3 The voting on all motions shall be by a show of hands or by secret ballot if ordered by the Regional Division Head or, if requested, by a majority of those present. In case of a tie, the presiding officer shall have the deciding vote.
- 2.13.4 Attendance
- 2.13.4.1 Provisional Staff Members shall attend at least 50% of their Primary Regional Department or Regional Division meetings in a calendar year, unless excused by the Regional Department Head for just cause.
- 2.13.4.2 Attendance at Regional Division meetings may be in person or by video or teleconferencing.
- 2.13.4.3 Active Staff Members shall attend at least 50% of their Primary Regional Department or Regional Division meetings in a calendar year, unless excused by the Regional Department Head for just cause. HAMAC will be notified of all exceptions and excusals.
- 2.13.5 Quorum
- 2.13.5.1 At Regional Division meetings a quorum shall consist of 50% of the voting members of the Regional Division.

2.14 REGIONAL DIVISION HEAD

- 2.14.1 Each Regional Division Head shall be a Member of the Active Staff and a member of the Regional Division
- 2.14.2 The Regional Division Head shall report to and be accountable to the Regional Department Head for the activities of the Regional Division and its members.
- 2.14.3 The Regional Division Head will be remunerated for services as the Regional Division Head at a rate agreed to by the FHA.
- 2.14.4 Appointment as Regional Division Head and remuneration for the position shall be detailed in a contract outlining the role description, position responsibilities, objectives of the role and accountabilities.
- 2.14.5 The term of appointment for each Regional Division Head shall be three years, renewable by recommendation of the Regional Department Head.

2.15 RESPONSIBILITIES OF THE REGIONAL DIVISION HEAD

- 2.15.1 The responsibilities of Regional Division Head shall include (but not be limited to):
- developing annual operating objectives for the Regional Division

- functioning as the channel of communication to and from the Regional Division to keep members of the Regional Division informed regarding Division objectives, policies and general activities
- developing, with the members of the Regional Division, standards of clinical practice for the Regional Division, recommending those standards to the Regional Department and ensuring that the Regional Division members work within established standards
- ensuring that programs for the continuing medical education of Regional Department members are established
- arranging and chairing Regional Division meetings as required in these Rules
- if applicable, working with Universities to ensure that education programs and research activities are being sufficiently promoted and supported
- promoting health and wellness amongst Members
- encouraging a healthy, respectful workplace
- investigating complaints regarding care provided by Members within the Regional Division under the direction of the relevant Regional Department Heads or Program Medical Directors
- reviewing with the Regional Division and the Regional Department Head and /or Program Medical Director, the manpower requirements of the Regional Division
- contributing to the search and selection of applicants for vacancies in the Regional Division

2.16 SELECTION PROCESS FOR REGIONAL DIVISION HEADS

- 2.16.1 Where a vacancy exists or following a resignation in the position of Regional Division Head, a search for a Regional Division Head shall be conducted.
- 2.16.2 The search for a Regional Division Head shall be undertaken by a duly appointed Search and Selection Committee.
- 2.16.2.1 The Search and Selection Committee will be established by and include the relevant Regional Department Head and shall include at least three (3) members of the Regional Division providing representation from each facility in which the Regional Division is active, and others as determined necessary and appropriate by the committee members, including those necessary in order to comply with a relevant Affiliation Agreement.
- 2.16.2.2 The members of the Regional Division may suggest relevant names for consideration by the Search and Selection Committee.
- 2.16.2.3 The process used by the Search and Selection Committee shall comply with relevant corporate policies in force at FHA.

- 2.16.3 The Regional Department Head shall forward the recommendation of the Search and Selection Committee for a Regional Division Head candidate to HAMAC.
- 2.16.4 HAMAC shall review the recommendation of the Search and Selection Committee and, if in agreement, recommend to the Board the appointment of the Regional Division Head candidate.

2.17 SUSPENSION OR TERMINATION OF REGIONAL DIVISION HEADS

- 2.17.1 The Board may, on the recommendation of the HAMAC, Vice President Medicine, VP Clinical Operations and/or CEO, suspend or terminate the appointment of any Regional Division Head. Prior to such suspension or termination notice shall be given in accordance with a relevant contract and HAMAC members shall be notified.
- 2.17.2 Suspension or termination of an appointment as Regional Division Head does not affect appointment to the medical staff of privileges.

2.18 HEAD OF DEPARTMENT (LOCAL)

- 2.18.1 Regional Departments will select a Head of Department (local) for every facility in which that Regional Department has Members.
- 2.18.2 The Head of Department (local) for each facility will be part of the Multidisciplinary Healthcare Coordinating Committee for that facility.
- 2.18.3 Each Head of Department (local) shall be an Active Staff Member who is assigned to the Regional Department and to that facility as the Member's primary site, and who shall be appointed by the Board upon the recommendation of HAMAC.
- 2.18.4 The Head of Department (local) shall be known as Head of (department name) for (facility name)
- 2.18.5 The Head of Department (local) shall report to and be accountable to the Regional Department Head for the activities of the Regional Department and its members.
- 2.18.6 The Head of Department (local) will be remunerated for services as the Head of Department (local) at a rate agreed to by the FHA.
- 2.18.7 Appointment as Head of Department (local) and remuneration for the position shall be detailed in a contract outlining the role description, position responsibilities, objectives of the role and accountabilities.
- 2.18.8 The term of appointment for each Head of Department (local) shall be two years, renewable by the Regional Department Head.

2.19 RESPONSIBILITIES OF THE HEAD OF DEPARTMENT (LOCAL)

- 2.19.1 The Head of Department (local) shall be responsible for (but not limited to):
- participating in the Multidisciplinary Healthcare Co-ordinating Committee for the facility

- functioning as the channel of communication to and from the Regional Department to keep Members practicing within the facility informed regarding FHA, HAMAC and Departmental objectives, policies and general activities and to ensure Regional Departments are aware of issues specific to the facility
- ensuring the requirements of programs operating within the facility are coordinated
- promoting health and wellness amongst Members
- investigating complaints regarding care provided by Members within the Department at the Facility under the direction of the appropriate Regional Department Head(s)
- encouraging a healthy, respectful workplace
- reviewing with the Regional Department Head the human resource requirements of the Regional Department practicing within the facility
- contributing to the search and selection of applicants for vacancies in the Regional Department

2.20 SELECTION PROCESS FOR HEAD OF DEPARTMENT (LOCAL)

- 2.20.1 Where a vacancy exists or following a resignation in the position of Head of Department (local), a search for a Head of Department (local) shall be conducted.
- 2.20.2 The search for a Head of Department (local) shall be undertaken by a duly appointed Search and Selection Committee.
- 2.20.2.1 The Search and Selection Committee will be established by and include the relevant Regional Department Head and shall include at least two (2) members of the Regional Department at the facility, the Hospital Medical Coordinator or delegate, individuals from the facility appointed by the facility administration plus others as determined necessary and appropriate by the described members, including those necessary in order to comply with a relevant affiliation agreement.
- 2.20.2.2 The members of the Regional Department at the facility may suggest relevant names for consideration by the Search and Selection Committee.
- 2.20.2.3 The process used by the Search and Selection Committee shall comply with relevant corporate policies in force at FHA.
- 2.20.3 The Regional Department Head shall forward the recommendation of the Search and Selection Committee for a Head of Department (local) candidate, to HAMAC.
- 2.20.4 HAMAC shall review the recommendation of the Search and Selection Committee and, if in agreement, recommend to the Board the appointment of the Head of Department (local) candidate

2.21 SUSPENSION OR TERMINATION OF HEAD OF DEPARTMENT (LOCAL)

- 2.21.1 The Board may, on the recommendation of the FHA HAMAC or the Vice President Medicine, VP Clinical Operations and/or CEO, suspend or terminate the appointment of any Head of Department (local). Prior to such suspension or termination notice shall be given in accordance with a relevant contract and HAMAC members shall be notified.
- 2.21.2 Suspension or termination of an appointment as Head of Department (local) does not affect appointment to the medical staff of privileges.

2.22 HOSPITAL MEDICAL COORDINATOR

- 2.22.1 The Hospital Medical Coordinator for a facility will be accountable to the Executive Director responsible for the facility.
- 2.22.2 The Hospital Medical Coordinator shall be a member of the Active Category of the Medical Staff with privileges to practice at the facility.
- 2.22.3 The President of the facility Medical Staff Association shall not be eligible for appointment to the role of Hospital Medical Coordinator.

2.23 RESPONSIBILITIES OF THE HOSPITAL MEDICAL COORDINATOR

- 2.23.1 The Hospital Medical Coordinator shall have authority for and responsibility for coordinating the activities of the facility medical staff, including:
 - 2.23.1.1 assisting the relevant program medical leadership to ensure the medical staff activities at the facility are consistent with the overall facility and program direction and role within FHA's service delivery plan
 - 2.23.1.2 assisting the Heads of Department (local) to ensure medical staff practices are aligned with other facility and program activities and initiatives
 - 2.23.1.3 assisting Heads of Department (local) in the identification of manpower needs and in the active recruitment of medical staff members
 - 2.23.1.4 working with the Heads of Department (local) under the direction of the Regional Department Head in the investigation of complaints regarding care provided by Members within the facility.
- 2.23.2 Hospital Medical Coordinators from each facility may form a FHA Advisory Committee chaired by the Vice President Medicine.

2.24 SELECTION PROCESS FOR HOSPITAL MEDICAL COORDINATOR

- 2.24.1 Where a vacancy exists or following a resignation in the position of Hospital Medical Coordinator, a search for a Hospital Medical Coordinator shall be conducted.
- 2.24.2 The search for Hospital Medical Coordinator shall be undertaken by a duly appointed Search and Selection Committee.

- 2.24.2.1 The Search and Selection Committee will be established by and include the relevant Executive Director and shall include at least two (2) physician members of the facility's Multidisciplinary Healthcare Coordinating Committee, the Vice President Medicine or delegate, individuals from the facility appointed by the facility administration plus others as determined necessary and appropriate by the described members, including those necessary in order to comply with a relevant affiliation agreement.
- 2.24.2.2 The process used by the Search and Selection Committee shall comply with relevant corporate policies in effect at FHA.
- 2.24.3 The Executive Director shall forward the recommendation of the Search and Selection Committee for a Hospital Medical Coordinator candidate, via the Vice President Medicine, to HAMAC.
- 2.24.4 HAMAC shall review the recommendation of the Search and Selection Committee and, if in agreement, recommend to the Board the appointment of the Hospital Medical Coordinator candidate.

2.25 SUSPENSION OR TERMINATION OF HOSPITAL MEDICAL COORDINATOR

- 2.25.1 The Board may, on the recommendation of HAMAC or the Vice President Medicine, VP Clinical Operations (on the advice of the Executive Director) and/or CEO, suspend or terminate the appointment of any Hospital Medical Coordinator. Prior to such suspension or termination notice shall be given in accordance with a relevant contract and HAMAC members shall be notified.
- 2.25.2 Suspension or termination of an appointment as Hospital Medical Coordinator does not affect appointment to the Medical Staff or privileges.

2.26 MULTIDISCIPLINARY HEALTHCARE CO-ORDINATING COMMITTEE

All meetings of the Multidisciplinary Healthcare Coordinating Committee shall be conducted according to Robert's Rules of Order, newly revised. Records of all meetings shall be kept.

- 2.26.1 Each facility shall have a Multidisciplinary Healthcare Coordinating Committee that meets at least ten(10) times per year.
- 2.26.2 Minutes of the Multidisciplinary Healthcare Coordinating Committee shall be made available to the Vice President Medicine and HAMAC.
- 2.26.3 Members of the Medical Staff who are members of the Multidisciplinary Healthcare Coordinating Committee have a right to identify areas of concern arising over the quality and availability of clinical care. These concerns may be communicated in writing or, if agreed to by the chair of HAMAC, in person to HAMAC.
- 2.26.4 The committee shall have representation in its membership of the Heads of Department (local) of each Regional Department active on the site, the President of the facility Medical Staff Association, other Members (of the Medical Staff) identified by the President of the Medical Staff Association as well as representation from the nursing and the allied health professional

staff. The committee may include representation from local community programs.

- 2.26.5 The Multidisciplinary Healthcare Coordinating Committee shall be co-chaired by the facility Site Director and the Hospital Medical Coordinator. The co-chairs of the Multidisciplinary Healthcare Coordinating committee shall be jointly responsible for coordinating the day to day activities of the facility.
- 2.26.6 Subject to the minimum numbers in article 2.26.4 the numbers of each staff group on the committee shall be jointly determined by the co-chairs.
- 2.26.7 Where a facility has few Regional Departments active, the committee may increase the numbers of representatives from those Regional Departments.
- 2.26.8 The committee may create sub-committees to focus on specific issues and these sub-committees may, where appropriate, consist of members from individual professional groups such as physicians and/or specialties and/or community programs.
- 2.26.9 The committee shall ensure the requirements of different Programs operating within the facility are coordinated.
- 2.26.10 The committee shall ensure issues related to the delivery of clinical care within the facility are identified, where possible managed locally and, where necessary, escalated to the relevant Regional Department(s) / Programs for resolution.
- 2.26.11 The committee shall advise the HAMAC of any concerns relating to the appointment or privileges of a Member (of the Medical Staff) practicing within the facility.

2.27 PROGRAM MEDICAL DIRECTOR

- 2.27.1 A Program Medical Director will be appointed for each clinical Program.
- 2.27.2 Each Program Medical Director shall usually be a member of the Active Staff.
- 2.27.3 The Program Medical Director shall report to and be accountable to the VP Clinical Operations, and be professionally accountable to the Vice President Medicine via the Executive Medical Director.
- 2.27.4 The Program Medical Director will be remunerated at a rate agreed with the FHA.
- 2.27.5 Appointment as Program Medical Director and remuneration for the position shall be detailed in a contract outlining the role description, position responsibilities, objectives of the role and accountability.
- 2.27.6 The term of appointment as Program Medical Director shall be five (5) years, renewable upon recommendation by the VP Clinical Operations and Vice President Medicine.
- 2.27.7 In recommending re-Appointment of a Program Medical Director the VP Clinical Operations and Vice President Medicine shall consider the results of annual performance reviews.

2.27.8 The performance review shall be conducted jointly by the VP Clinical Operations and the Vice President Medicine and shall include, but not be limited to input from:

- Executive Director of the Program
- Nursing leaders within the Program
- Members within the Program
- Regional Department Heads within the Program
- Facility or community Program Representative from the Multidisciplinary Healthcare Coordinating Committee

2.28 RESPONSIBILITIES OF THE PROGRAM MEDICAL DIRECTOR

2.28.1 The Program Medical Director shall be jointly responsible with the Executive Director for the delivery of healthcare within the Program. Specific responsibilities shall include (but not be limited to):

- co-leading the Program with the Executive Director to set standards / guidelines of healthcare delivery and develop systems for monitoring compliance with those standards
- meeting regularly with the senior administrative team and the VPs regarding ongoing issues of patient care and Member practice
- ensuring that Member activities are consistent with the overall direction of the FHA service delivery plan
- liaising with Medical Directors of other FHA Programs to ensure the services Program provides are coordinated with the other Programs to provide a spectrum of care to the patients, residents and clients
- meeting regularly with inter-disciplinary clinical leaders and administrators to ensure that Member practices are aligned with other activities and initiatives within the inter-disciplinary team
- maintaining a high degree of visibility by regular visits to each facility in which the regional department is active
- assisting Regional Department Heads in the identification of manpower needs and in the active recruitment of practitioners
- assisting Regional Department Heads in dealing with quality of care issues including issues regarding performance, availability and the behaviours of individual Regional Department Members
- ensuring new Members are adequately oriented to facilities and Program policies, procedures and practices to allow their smooth integration into the Medical Staff
- ensuring investigation of complaints regarding care provided by Members within the Program

- representing the Medical Staff in public on an as requested basis on issues of Medical Staff policies, procedures and quality of care
- ensuring that Member academic activities (including education and research) are compliant with FHA policies.

2.29 SELECTION PROCESS FOR PROGRAM MEDICAL DIRECTORS

- 2.29.1 Where a vacancy exists or following a resignation in the position of Program Medical Director, a search for a Program Medical Director shall be conducted.
- 2.29.2 The appointment a Program Medical Director shall be undertaken by a duly appointed Search and Selection Committee.
- 2.29.2.1 For Program Medical Directors, the Search and Selection Committee shall include the VP Clinical Operations, the Vice President Medicine, an Executive Medical Director, two Regional Department or Regional Division Heads and an elected officer of the medical staff association, plus others as determined necessary by the described members.
- 2.29.2.2 When required by the Affiliation Agreement, a University appointed representative should be added to the Search and Selection Committee.
- 2.29.2.3 The process used by the Search and Selection Committee shall be determined by relevant corporate policies in force at FHA.

ARTICLE 3 – APPOINTMENT AND PRIVILEGES

3.1 APPOINTMENT TO THE MEDICAL STAFF

- 3.1.1 The procedure for appointment and basic criteria for membership of the Medical Staff is outlined in the Bylaws, Article 4.
- 3.1.2 The process for application for appointment to the Medical Staff of FHA involves the assessment of professional credentials, competence, performance, professional suitability and the assessment of FHA service requirements and the capacity of the available resources to support the scope of practice.
- 3.1.3 Subject to the review and appeal procedures described in the Bylaws and these Rules, the Board makes the final decision regarding every appointment. The Board may refuse to appoint a practitioner to or continue the appointment of a Member of the Medical Staff, or may modify, suspend or revoke appointments and privileges of any Member in accordance with the Bylaws on such grounds as may be specified by the Board, including but not limited to: availability of resources, professional incompetence, unprofessional, disruptive or unethical conduct, inadequacy of professional liability insurance, breach of these Rules, failure to comply with all relevant legislation or the Bylaws or with orders, directions and requests of the Board or the CEO.

3.2 PROCESS FOR APPLICATION, SEARCH AND SELECTION

- 3.2.1 The Bylaws outline the process for application to the Medical Staff. The Rules outline the appointment procedure in more detail. Most commonly, recruitment will occur in the following steps:
 - 3.2.1.1 After a vacancy is declared applicants will initially apply for the position providing a letter of interest, curriculum vitae (CV) and names of three (3) referees.
 - 3.2.1.2 A search and selection committee will be established by the relevant Program Medical Director in consultation with the Regional Department Head and will shortlist the candidate(s) who may then receive a comprehensive release form to sign allowing additional information and references to be gathered. All shortlisted candidates will be interviewed.
 - 3.2.1.3 The search and selection committee will select a preferred candidate or candidates using preset criteria to guide the process
 - 3.2.1.4 The selected candidate(s) will receive an application package for appointment to the Medical Staff of FHA
 - 3.2.1.5 Those who are not selected will be notified in writing that the position(s) available has been offered to other candidates
 - 3.2.1.6 The Head of Department (local) and Regional Department Head will ensure requested privileges are consistent with the candidate's experience and training and with local resources and Program requirements.
 - 3.2.1.7 HAMAC will review the completed application for appointment documentation of the selected candidates pursuant to Article 4 of the Bylaws. HAMAC may not change the Search and Selection Committee's selection of preferred candidate(s).
- 3.2.2 Search and Selection Committee
 - 3.2.2.1 The Search and Selection Committee should have membership that reflects relevant Programs, Regional Departments, facilities, multidisciplinary representatives of involved allied health professional staff and administration and, when appropriate, academic interests.
- 3.2.3 Application process when no vacancy is declared
 - 3.2.3.1 The procedure for appointment and process for application to the Medical Staff is as set out in Article 4 of the Bylaws.
 - 3.2.3.2 Unsolicited letters of intent to apply for membership on the Medical Staff will be reviewed by the relevant Regional Department Head and Program Medical Director(s) to determine if there is a need for the practitioner within the Program.
 - 3.2.3.3 If there is no vacancy, the applicant will be contacted in writing informing him/her that there is no vacancy.

3.3 LOCUM TENENS AND TEMPORARY STAFF

- 3.3.1 Appointments to the Locum Tenens Staff and Temporary Staff categories are governed by the relevant Articles of the Bylaws.
- 3.3.2 The term of appointment of Locum Tenens and Temporary Staff shall not exceed 12 months.
- 3.3.3 An appointment to the Locum Tenens Staff provides no preferential access to an Active, Provisional or other appointment at some later time.
- 3.3.4 The purpose of an appointment to the Locum Tenens Staff is to replace an absent Member of the Active, Provisional or Consulting Staff or for the purpose of replacing the filling the duties of a vacant medical staff position.
- 3.3.5 A Member on temporary leave is responsible to determine what aspects of his/her practice the covering practitioner is prepared and qualified to cover, and for making arrangements with other Members to attend to those aspects of the practice that the covering practitioner will not cover.
- 3.3.6 An application for appointment to the Locum Tenens Staff must be supported by the Head of Department (local) and recommended by the Regional Department Head.
- 3.3.7 The purpose of an appointment to the Temporary Staff category is to fill a temporary service need.
- 3.3.8 An application for appointment to the Temporary Staff must be supported by the Head of Department (local) and recommended by the Regional Department Head

3.4 PROCEDURAL PRIVILEGES

- 3.4.1 Procedural privileges are granted by the Board upon the recommendation of HAMAC
- 3.4.2 The Board may grant procedural privileges in a specialty to a Member within the scope and type of procedures defined by the FHA's clinical service delivery in that specialty area, and by the specific training, demonstrated expertise and current practice of the Member.
- 3.4.3 Procedural privileges will be defined, reviewed and amended periodically by HAMAC.
- 3.4.4 Practitioners applying for appointment to the Medical Staff or Members may apply for procedural privileges. All procedural privileges require documented proof of required training and experience as specified by HAMAC.
- 3.4.5 Application for procedural privileges must be supported by the Head of Department (local) and the Regional Department Head.
- 3.4.6 Procedural privileges may be automatically granted to all Medical Staff members within defined departmental or divisional categories.
- 3.4.7 The granting of procedural privileges is dependent on the training, experience and qualifications of the applying practitioner or Member, on the service needs of FHA, and the ability of FHA to provide adequate resources and

- staff to support the performance of any procedure to which the privileges relate.
- 3.4.8 “Advanced” procedural privileges (e.g. GP/Anesthesia) are those privileges for which additional training is required.
- 3.4.9 Practitioners applying for an appointment to the Medical Staff or Members must specifically apply for procedural privileges in the following circumstances:
- 3.4.9.1 The introduction of new technology for which education and training has not previously been available to the specialty
 - 3.4.9.2 A request for procedural privileges outside the applicant’s specialty area
 - 3.4.9.3 A request by a non-Specialist for procedural privileges in a specialty area
 - 3.4.9.4 A request by a Specialist for procedural privileges in a specialty area other than those of his primary Regional Department or Division
 - 3.4.9.5 A request for privileges generally not included in a specific staff category as defined in the Bylaws.
- 3.4.10 The Regional Department Head, in consultation with the applicable Regional Division Head, will ensure all FHA corporate and clinical policies relating to new procedures are adhered to.
- 3.4.11 The Regional Department Head, in consultation with the applicable Regional Division Head, will determine and evaluate the training and experience required or gained by an applicant to support his or her request for specific procedural privileges. This may include supervision of the procedure by qualified Members for a number of cases.
- 3.4.12 The training and experience requirements for specific procedural privileges will be determined as a standard for all new applicants.
- 3.4.13 In exceptional circumstances, the Regional Department Head, in consultation with the applicable Regional Division Head, may determine and evaluate the training and experience on an individual basis if the applicant does not meet the standard for new applicants but can demonstrate training and experience of a similar validity supportive of comparable competency.
- 3.4.14 Procedural privileges may be granted to a Member on the basis of adequate documentation provided by another Health Authority or facility where that Physician has obtained such privileges.
- 3.4.15 Where specific procedural privileges have been granted, the Board in consultation with the Regional Department Head and HAMAC, may specify the frequency at which such a procedure should be performed for this procedural privilege to be retained by the Member.

3.5 TEMPORARY APPOINTMENTS AND TEMPORARY PRIVILEGES

- 3.5.1 A temporary appointment to the Medical Staff with temporary privileges, including procedural privileges, may be granted by the relevant Regional Department Head, Executive Medical Director or CEO following consultation with the Head of Department (local) at the relevant facilities
 - 3.5.1.1 to a practitioner without application under special or urgent circumstances such as a medical emergency, organ retrieval, infant and maternal transport, education, demonstration of medical equipment., or
 - 3.5.1.2 to a practitioner who has applied for an appointment to the Medical Staff and there is a demonstrated need for the applicant to begin to provide clinical services in advance of a Board meeting to consider the application.
- 3.5.2 The interim nature of the temporary appointment with temporary privileges shall be clearly indicated to the practitioner and, where applicable, indicated as such on all notices and correspondence regarding an applicant's appointment.
- 3.5.3 Except as indicated in 3.5.1.2, the granting of a temporary appointment with temporary privileges provides temporary member no preferential access to an appointment to categories of the Medical Staff at a later time.
- 3.5.4 The temporary appointment with temporary privileges must be ratified or terminated by the Board at its next meeting.
- 3.5.5 If the next Board meeting falls in advance of the next HAMAC meeting to consider the temporary member's application for appointment, the Board may, on the advice of HAMAC, extend the temporary appointment with temporary privileges until the next scheduled Board meeting.
- 3.5.6 In the event that the Board terminates the temporary appointment with temporary privileges, the applicant shall cease all clinical activity in facilities and Programs and immediately transfer the ongoing care of any patient under his/her care to an appropriate Member.

3.6 HAMAC – APPOINTMENTS AND REVIEW PROCESSES

- 3.6.1 HAMAC is responsible for reviewing all applications for appointment to and renewal of membership on the Medical Staff made by practitioners and Members consistent with the Bylaws and, subsequently, making recommendations to the Board.
- 3.6.2 HAMAC, in conjunction with the relevant Regional Department Head(s), is responsible for recommending the appointment and the privileges for which the applicant has demonstrated competency and which the applicant may exercise in the facilities.
- 3.6.3 HAMAC will ensure that each applicant has the recommendation of the Head of Department (local) to perform the requested privileges in that facility prior to recommending appointment to the Medical Staff.

- 3.6.4 HAMAC is responsible for recommending the appointment of an applicant to a Medical Staff category Primary Regional Department, and other Departments (if applicable), and Primary Site based on the recommendation of the Regional Department Head and agreement of the Head of Department (local) and applicant.
- 3.6.5 Subject to article 4.6 of the Bylaws, a Member has the right to request through HAMAC a change in the category, primary site or Regional Department(s) to which the Member was appointed and privileges if the Member is able to provide information indicating a practice pattern that currently supports his/her request.

3.7 REVIEW OF APPOINTMENT AND PRIVILEGES

- 3.7.1 Each Member shall have his/her appointment and privileges reviewed on a regular basis. The procedure for review is outlined in the Bylaws.
- 3.7.2 The interval between regular reviews will be two (2) years.
- 3.7.3 The regular review of appointment and privileges shall be conducted by the Regional Department Head of the Primary Regional Department to which the Member has been appointed, or by another Member delegated to do so on behalf of the Regional Department Head. The Regional Department Head or delegate should discuss the results of the regular review with the Member in person
- 3.7.4 The regular review of appointment and privileges shall include, but not necessarily be limited to, compliance with the Bylaws and the Rules, compliance with policies and procedures, satisfactory chart completion, satisfactory conduct, satisfactory completion of orientation refresher training as defined in Appendix 2 of the Rules and the presence or absence of complaints.
- 3.7.5 The Regional Department Head or delegate shall advise HAMAC directly of his/her recommendations.
- 3.7.6 In assessing the impact of complaints resulting in disciplinary action or repetitive complaints of a similar nature on the privileges review, consideration should be given to input from the Medical Staff or Physician Health Committee, if applicable.
- 3.7.7 Changes in resource availability at the facility or in the Program, or different needs for services in the community, may also affect the decision to recommend renewal of membership.
- 3.7.8 Additional criteria for the regular review of appointments and privileges shall be determined by HAMAC.

3.8 IN DEPTH REVIEW

The Bylaws state that in depth performance evaluations should be performed on all Medical Staff at least every three years and shall consist of a formal review of the member's practice. Details for this type of evaluation are described in Appendix 3 of the Rules.

3.9 ALLIED HEALTH PRACTITIONERS

All modes of care and treatment for patients within the facilities and Programs of the FHA shall be provided only by employees of the FHA or regulated health professionals granted permission by the Board to practise.

Health professionals who are employees of FHA are not subject to section 7(7) of the *Hospital Act Regulation* and are not appointed to the Medical Staff.

Consistent with section 7(7) of the *Hospital Act Regulation*, non-employee regulated health care professionals other than physicians, midwives, nurse practitioners and dentists may apply for permission to practice in FHA facilities. These “allied health practitioners” may not be appointed to the Medical Staff.

The Board may permit allied health practitioners to provide health care services to patients provided the admission, medical care and discharge responsibilities rest with a Member with admitting privileges.

3.9.1 Podiatrists

Podiatrists with permission to practice in FHA facilities and Programs may provide treatment and patient care within the scope of their professional practice. Podiatrists may not admit or discharge patients or otherwise function as a patient’s most responsible practitioner (MRP).

Once an MRP has admitted a patient, he or she may designate a Podiatrist with permission to practice to treat patients by writing an order on the chart, “Podiatrist to treat”. Once designated, a Podiatrist may, in consultation as needed with the MRP, and within the limits of their competence, scope of autonomous practice, and in accordance with any applicable article of the Bylaws or these Rules:

- order diagnostic tests
- diagnose diseases, disorders or conditions
- order drugs or other therapies

3.9.2 Scientific or Professional Staff

Persons with appropriate qualifications, such as PhD, Pharm D, etc., who are not licensed to practice medicine, midwifery, as a nurse practitioner or dentistry but whose services are required by the FHA may work in conjunction with or under the direction of a designated member. They may attend patients at the request of a Member of the Active or Provisional Staff and provide services within the scope of the standards, limits and conditions of their governing professional body.

ARTICLE 4 – RESIDENTS, CLINICAL FELLOWS, CLINICAL TRAINEES & MEDICAL STUDENTS

4.1 RESIDENTS

4.1.1 Assignments

All Resident assignments shall be made through the office of Medical Postgraduate Education in conjunction with a Faculty of Medicine formally affiliated with the Fraser Health Authority and the College of Physicians & Surgeons of British Columbia.

4.1.2 Scope of Activity

Residents may attend patients under the supervision of a Member of the Active or Provisional Staff of the Regional Department responsible for supervision of the Resident's practice in the facility. They may carry out such duties as are assigned to them by the Member to whom they have been assigned. (Further details of Resident roles and responsibilities are contained in the Residents Manual available through the office of Medical Postgraduate Education of their University of affiliation).

4.2 CLINICAL FELLOWS

4.2.1 Appointments

Clinical Fellows are Practitioners who have applied to and been accepted by the FHA for further training in a clinical discipline. They must have adequate medical liability insurance, be licensed by the relevant professional College and be registered with a Faculty of a university formally affiliated with the Fraser Health Authority. Clinical Fellows shall be accepted only if supported by the Regional Department Head and if recommended by HAMAC and approved by the Board.

4.2.2 Scope of Activity

Clinical Fellows may attend patients under the supervision of a Member of the Active or Provisional Staff of the Regional Department responsible for supervision of their work in the facility. They may carry out such duties as are assigned to them by the Regional Department Head or delegate to whom they have been assigned. They may not be a patient's Most Responsible Practitioner (MRP) nor may they vote at Medical Staff or Regional Department meetings.

4.3 CLINICAL TRAINEES

4.3.1 Appointments

Clinical Trainees are Practitioners who have applied to and been accepted by the FHA for further clinical training. They must have adequate liability insurance and be licensed by the relevant professional College. Clinical Trainees shall be accepted only if supported by the Regional Department Head concerned and recommended by HAMAC and approved by the Board.

4.3.2 Purpose and Scope

The purpose of a Clinical Traineeship is to provide a licensed Practitioner an opportunity to maintain or enhance their clinical skills. Clinical Trainees may attend patients under the supervision of a Member of the Active or Provisional Staff of the Regional Department responsible for supervision of their work in the facility. They may carry out such duties as are assigned to them by the Regional Department Head or delegate to whom they have been assigned. They may not be a patient's MRP nor may they vote at Medical Staff or Regional Department meetings.

4.4 MEDICAL STUDENTS

All Medical Students, including those attending Universities outside B.C., who are working within a Program or Regional Department, must be registered with a recognized Faculty of Medicine and require an educational license from the College of Physicians and Surgeons of B.C. Medical Students will receive practical clinical experience, under the direction of the University, as described in the Affiliation Agreement between the University and FHA. Medical Students may attend patients under the direct supervision of a Member of the Active or Provisional Medical Staff, Resident Staff or Clinical Fellow in the Regional Department responsible for their training program. Medical Students must ensure that orders are countersigned by the supervising Physician, Resident or Clinical Fellow. Medical Students shall not sign certificates of death and shall not discharge patients without appropriate review by a qualified Physician.

ARTICLE 5 – RESPONSIBILITY FOR PATIENT CARE

5.1 ADMISSION, DISCHARGE AND TRANSFER OF PATIENTS

5.1.1 Pre-Admission requirements for elective patients

5.1.1.1 The admitting Member is responsible for pre-admission requirements for elective patients, the medical history, physical examination, diagnosis, investigations, appropriate consultations, special tests, documentation of special precautions and patient consent.

5.1.1.2 The Admitting Department shall inform the Most Responsible Practitioner (MRP) of the expected time for elective admissions.

5.1.2 Admission

5.1.2.1 The MRP is integral to the provision of quality health care, to the promotion of continuity of care and to the delivery of appropriate medical services. Every patient admitted for care and treatment in a FHA acute care facility must have a MRP who holds appropriate Fraser Health credentials and privileges and whose name shall be clearly identified in the patient's health care record at all times during the patient's hospitalization period.

- 5.1.2.2 Patients shall be admitted to a facility for investigation or treatment only upon the order of a Member who holds the requisite appointment and privileges.
- 5.1.2.3 Members of the Dental Staff who are not registered as certified Oral/Maxillofacial Surgeons of BC may not admit patients.
- 5.1.2.4 General/Restorative Dental and Podiatry admissions: A physician Member, who will be the MRP, must admit patients and residents admitted for general/restorative dental or podiatry treatment. The attending dental surgeon or podiatrist shall be responsible for the patient's dental or podiatry care.
- 5.1.2.5 The admitting Member shall be deemed to be the MRP until a Clear transfer of care occurs (see below, Transfer of Care).
- 5.1.2.6 Where two (2) or more Members are involved with the care of the patient, one (1) Member must be identified as the MRP at all times.
- 5.1.2.7 Where the admitting Member is an ER physician, the ER Physician shall be deemed to be the MRP until a clear transfer of care occurs (see below, Transfer of Care).
- 5.1.2.8 The Admitting Department shall provide notice of admission/discharge to the patient's family physician in the community within 24 hours of admission to an acute care facility.
- 5.1.2.9 The current FHA policy regarding the MRP shall be followed but is outlined in brief below:
- 5.1.2.9.1 The MRP is accountable and shall assume responsibility for the overall care provided to patients under their care regardless of the patient's location and shall:
- be aware of each patient for whom they are responsible.
 - when accepting care from the transferring Member, if necessary, review with the transferring Member and/or nursing staff the current medical orders for care of the patient.
 - assess and examine the patient, document his/her findings on the chart and issue the applicable order(s) for the patient:
 - as warranted by the patient's initial condition;
 - within 24 hours of admission or acceptance of transfer of care or sooner;
 - depending on the patient's condition.

- Communicate the patient's clinical status to the patient, the family/legal guardian and the other members of the health care team as appropriate.
- Ensure that each patient is seen by a Member 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. With the approval of HAMAC and the Executive Medical Director a Regional Department policy may allow for less frequent visitation to improve quality of care and patient safety.
- Complete daily progress notes in accordance with the Health Authority's documentation standards.
- 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.
- 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 Member.

5.1.2.10 For all admissions, the MRP will document the severity of the patient's condition and any circumstances necessitating special consideration.

5.1.2.11 The admitting Member shall note special precautions regarding the care of the patient on the patient's health record. Precautionary notes are required for, but not limited to, chemical dependency, potential suicide, violence, epileptic seizures, psychiatric conditions, communicable infections, drug reactions and allergies.

5.1.2.12 All patients and residents must have a record or summary of their history and physical examination placed on the patient/resident health record within twenty-four (24) hours of admission.

5.1.2.13 All patients and residents admitted for surgery must have a history and physical examination recorded on the patient/resident health record before surgery takes place.

5.1.3 Delegation of Responsibility

5.1.3.1 The MRP may delegate responsibility for the care of a patient to another Member. The MRP shall advise the health care team of the delegation and document the delegate's name and position on the patient's health record unless the MRP is designated as a

service. The MRP continues to have overarching responsibilities for the care of the patient.

- 5.1.3.2 The MRP can be designated as a service rather than an individual if it fulfills the criteria listed in terms of coverage and notification and is appropriate for the hospital and patient care.
- 5.1.3.3 For services where MRP responsibility is shared by a group and/or teaching practice, the Regional Department Head or his/her identified delegate for the service will be responsible for ensuring that a schedule of Member coverage is made readily available to the health care team.
- 5.1.3.4 The schedule of coverage will be posted in advance and will be made readily available to all Members and nursing staff and any changes updated immediately. The schedule of coverage will include the name of the Member who is covering during a specified period of time and his/her contact number(s).
- 5.1.3.5 It is the responsibility of the individual Member to find a replacement if they will not be available to cover their shift. The schedule will be kept on file in FHA for the same period of time as medical records.
- 5.1.3.6 In the event that a Member on the schedule is not available for any reason, the Regional Department Head or his/her identified delegate will be contacted and will be responsible for providing coverage for the service.
- 5.1.3.7 Routine coverage by the on-call group for the MRP will be documented and this information will be made readily available on the wards and to all Members and nursing staff within FHA.

5.1.4 Transfer of Responsibility

- 5.1.4.1 Members will ensure continuous coverage for their patients in the facility.
- 5.1.4.2 If a Member is away from practice (other than on-call) he/she shall indicate the name(s) of the Member(s) assuming responsibility for the patient's care on the health record and inform his/her Regional Department Head or designate. This pertains to the MRP and to any Consultants actively involved in the patient's care.
- 5.1.4.3 If a Member wishes to withdraw from involvement in a patient's care when services are still required, the Member shall inform the patient and arrange for another Member with appropriate qualifications from within the same specialty to assume responsibility for the care of the patient prior to withdrawing from care.
- 5.1.4.4 A patient has the right to request a change in the MRP or Consultant. The MRP shall cooperate in transferring responsibility for care to another Member who can provide appropriate care and is acceptable to the patient. If an acceptable alternative Member cannot be found, the MRP will discuss the issue with the relevant

Regional Department Head designate, who shall ensure that care for the patient is provided until the patient can be transferred to a Member who agrees to accept responsibility for the care of the patient and who is acceptable to the patient.

5.1.4.5 When the transfer of a patient to another facility is initiated by the MRP, the MRP or Designate shall ensure, prior to the patient being transferred, that there is a Member of the medical staff at the receiving facility who is fully informed about the patient's condition and is prepared to assume responsibility for the patient's care. The discussion between the two Members along with the date and time of the conversation and name of the accepting Member will be documented in the chart by the transferring Member. The transferring Member shall identify relevant documentation from the patient's health record to be sent to the receiving facility.

5.1.4.6 When the transfer of a patient to another facility is initiated or facilitated by the Regional Department Head or Designate, the MRP or Designate shall ensure, prior to the patient being transferred, that there is a Member at the receiving facility who is fully informed about the patient's condition and is capable of providing for the patient's care. The discussion between the two Members and the Regional Department Head or designate along with the date and time of the conversation and the name of the accepting Member will be documented in the health record by the transferring Member. The transferring Member shall identify relevant documentation from the patient's health record to be sent to the receiving facility.

5.1.5 Transfer of Care after Admission

5.1.5.1 The transfer of a patient's care may be necessary to ensure continuity of care and access to appropriate medical care. This should occur only if necessary during the acute care stay.

5.1.5.2 When an in-patient transfer of care is deemed appropriate by the MRP:

5.1.5.2.1 The MRP shall personally contact the intended accepting Member to obtain an agreement to accept transfer of care. Personal notification is expected in all circumstances.

5.1.5.2.2 The transfer of care takes place upon the acknowledgement of the accepting Member during a verbal discussion between the transferring Member and the accepting Member. The transferring Member is responsible to document in the chart the name of the Member who has accepted the transfer of care either for him/herself or on behalf of the Member group, along with the date and time of the verbal discussion that has occurred between the two Members. An order must be written in the patient's health care record by the

transferring Member instructing registration staff to change the name of the MRP to the accepting Member's name or to the accepting service. The name of the Member who accepts the care of the patient for a service will be written on the order sheet to document the transfer of MRP care to the service and the registration will show the service name as MRP.

- 5.1.5.2.3 For transfers that involve the BC Patient Transfer Network the transferring Member will dictate a priority discharge summary on the patient prior to the BC Patient Transfer Network being contacted for the transfer.
- 5.1.5.2.4 The accepting Member or Designate shall assess and examine the patient, document the findings and issue applicable order(s) as soon as warranted by the patient's condition but not longer than 24 hours after accepting the transfer and not less than once a day thereafter for as long as the patient remains under his/her care while the patient is deemed an acute care patient. With the approval of HAMAC and the Executive Medical Director a Regional Department policy may allow for less frequent visitation to improve quality of care and patient safety.
- 5.1.5.2.5 The Member or Designate accepting the transfer of care of a patient awaiting long term care placement shall assess and examine the patient as soon as warranted by the patient's condition but not longer than 24 hours after accepting the transfer and thereafter at least once during a seven (7) day period while the patient remains admitted to an acute care facility.
- 5.1.5.3 A Member may decline to accept responsibility of MRP from a transferring Member if the patient's primary condition is not reasonably considered to be within their skills, training or scope of practice.
- 5.1.5.4 The accepting Member will become the MRP only after the transferring Member has documented the name of the Member, and the time and date of acceptance of the patient's care by that Member on the chart as an order.
- 5.1.5.5 There must be a recorded response from the Member accepting the transfer of care documented on the chart within 24 hours, either by writing an order or progress note or communicating the verbal order "I accept care" to the nursing staff. Notation of the receipt of all relevant clinical information known at time of transfer should be made where appropriate.

5.1.6 Medical Consultations

- 5.1.6.1 Members are encouraged to obtain appropriate consultations that facilitate and enhance patient care. In the event a consultation is requested, the MRP shall:
 - 5.1.6.1.1 Where possible, notify the patient and/or the patient's family/legal guardian of the purpose of the consultation and the name of the Consultant.
 - 5.1.6.1.2 Communicate directly with the consulting Member, or their Designate, for any patients requiring an in-hospital consultation as per the B.C. College of Physicians and Surgeons guidelines unless Regional Department approved policy describes automatic consultation for a specified service.
 - 5.1.6.1.3 Ensure that the reason(s) and purpose for the consultation request is appropriately documented on the patient's health record.
- 5.1.6.2 The Consultant or Designate shall assess, examine the patient and document the findings, opinions and recommendations on the patient's health care record as soon as warranted by the patient's condition but not longer than 24 hours from receipt of notification unless otherwise arranged.
- 5.1.6.3 Parameters for the role of the consultant are outlined below:
 - 5.1.6.3.1 Consultation Only - Consultant asked to make an assessment and provide management suggestions. These suggestions will be written within the consult note and/or progress notes. The Consultant is not expected to write ongoing orders or to provide follow-up. In this case the MRP remains the same, and the Consultant does not write orders.
 - 5.1.6.3.2 Consultation with Directive Care - The Consultant assists with the ongoing care of the patient including writing appropriate orders and follow-up. The Consultant is not the MRP. The referring Member remains as the MRP. Clarification of any orders will first be the responsibility of the Member writing the orders with the MRP responsible for final clarification if necessary.
 - 5.1.6.3.3 Consultation with Continuing Care (Transfer of Care) - Consultant takes over the entire care of the patient and becomes the MRP. This initiates a transfer of care and the Consultant accepts care of the patient as the MRP and includes all patients that have been taken to the operating room for major surgery.
- 5.1.6.4 In the absence of clear direction, direct communication by the Consultant with the MRP should be undertaken for clarification.

The default obligation of the Consultant is an appropriate review, examination and recommendations only.

5.1.6.5 Consultation shall occur:

5.1.6.5.1 At the request of the MRP

5.1.6.5.2 In accordance with the relevant "Mandatory Consultation Policy"

5.1.6.5.3 Whenever requested by the Regional Department Head or Designate

5.1.6.6 If a Member declines a consultation that is within their scope of practice, the matter will be immediately elevated to the relevant Regional Department Head or designate for resolution.

5.1.7 Emergency Department Consultations and Shift Change Transfer of Care

5.1.7.1 The members of the Department of Emergency Medicine remain responsible for the care of all patients in the Emergency Department until such time as:

5.1.7.1.1 The patient is discharged from the Emergency Department; or

5.1.7.1.2 Patient care is transferred to an accepting MRP.

5.1.7.2 For all patients in the Emergency Department that have not been discharged or transferred to an accepting MRP at the time of shift change for the Emergency physician, a transfer of care will occur between the Emergency physician completing their shift and the Emergency physician starting their shift.

This transfer of care will take place upon the acknowledgement of the accepting Emergency physician during a verbal discussion between the transferring and Emergency physician.

The transferring Emergency physician is responsible to document in the chart the name of the Emergency physician who has accepted the transfer of care of the patient in the Emergency Department, along with the date and time of the verbal discussion that has occurred between the two physicians.

5.1.7.3 Where a patient is admitted from the Emergency Department to an inpatient unit at the same site, the Emergency physician will be identified as the Admitting physician. The MRP will be identified as the Attending Member.

The Attending Member assumes MRP responsibility for the patient as soon as the transfer of care has been arranged with the Emergency Physician.

5.1.7.4 Where a patient is admitted from another hospital or from the community directly to an inpatient bed (or into the ER if no inpatient bed is available) for elective surgery or continued inpatient care in an acute care facility, the Member who has

arranged the elective surgery or inpatient care, will be identified as both the Admitting and Attending Member. The Member who has accepted the transfer from another facility or directly from the community will be identified as both the Admitting and Attending Member.

- 5.1.7.5 If a patient requires transfer to another site for evaluation or admission, the appropriate local consultant will provide support to the emergency physician to facilitate said transfer.
- 5.1.7.6 In the case where a Member is consulted for a patient in the Emergency Department and the Member feels it is not within his/her scope of practice, the Member will assess the patient in a timely fashion. If, after assessing the patient, the Member has determined the patient's admission is not appropriate for their specialty area, the Member should discuss the case with the Emergency physician and, in conjunction with the Emergency physician, make a decision about from whom the most appropriate consultation would be and who initiates that consultation request. If the Emergency physician who made the initial request for consultation has already completed their shift when the consultant has completed his/her assessment, the consultant will discuss the case with the on duty Emergency physician who has accepted ongoing care of the patient from the Emergency physician who has completed their shift.

5.1.8 Health Care Team Member Responsibilities

- 5.1.8.1 The patient's nurse (or designate), Clinical Associate/Assistant or Resident shall immediately notify the MRP (or Designate):
- of any significant change in the patient's condition; and
 - document the above actions in the patient's health record.
- 5.1.8.2 The patient's nurse (or designate) will immediately document in the chart any changes to the MRP and notify the Admitting Department to acquire updated identification labels to reflect the new MRP.

5.1.9 Discharge

- 5.1.9.1 Only the MRP or a Designate may authorize discharge of patients from the facility.
- 5.1.9.2 In exceptional circumstances, a patient may be discharged by a Program Medical Director, Regional Department Head or a Designate.
- 5.1.9.3 Discharge planning begins at the time the decision is taken to admit the patient. The MRP is responsible for identifying the "estimated date of discharge" (EDD) from acute care, which should be included in the initial orders and updated regularly throughout the stay. The reason for any change of EDD should be clearly documented for future audit.

- 5.1.9.4 Members shall, when possible, flag the planned discharge on the day prior to discharge. Discharge orders shall be written for all patients or residents as early as possible on the day of discharge or, ideally by 1100 hours on the day of discharge or, where possible, on the day prior to discharge. All discharged patients and residents should normally leave the facility by 1200 hours. In unusual circumstances where additional information becomes available later that permits a patient to be discharged safely, the order should be written immediately to expedite the discharge no matter what time of day.
- 5.1.9.5 Any alterations to the discharge plan following the discharge order must be documented on the health record, including new discharge orders.
- 5.1.9.6 Should a patient demand to be allowed to leave the facility against MRP's advice, the patient shall be asked to sign a release on the prescribed form. Refusal to sign this release must be noted in the medical record. Patients who have been absent without a pass for greater than six (6) hours past the end of an official pass period, are deemed "Discharged Against Medical Advice". Involuntarily hospitalized psychiatric patients are excluded from this rule. If these psychiatric patients are absent without a pass for greater than six (6) hours and their whereabouts are unknown, notification should be given to the appropriate authorities.
- 5.1.9.7 A discharge summary shall be dictated within forty-eight (48) hours of a patient's discharge. Issues significant to the patient's immediate follow-up shall be communicated by the MRP at the time of discharge directly to relevant health care professionals who will be involved in care pending receipt of the discharge report.

5.1.10 Diagnostic Tests

The follow-up of test results and treatment is the responsibility of the ordering or treating Member, unless other Members involved in the patient's care have been informed and have explicitly agreed to assume this responsibility. Any forms or documentation requirements are similarly the obligation of the MRP.

5.2 HEALTH RECORDS

The MRP involved in the patient's care shall be responsible for the preparation of the medical component of the health record for each patient.

The patient's health record shall clearly indicate the up-to-date name of the MRP, including the time and date of any transfer of care

The record shall include the following items, where applicable:

5.2.1 Admission History

- 5.2.1.1 The MRP shall ensure that every patient admitted to the facility shall have within twenty-four (24) hours after admission, and prior to every delivery or operation except in extreme emergency, an

adequate clinical history and physical examination and provisional diagnosis recorded in the health record. If the admission history is dictated, then a brief written note must be placed in the chart indicating the relevant history and indicating a complete admission history has been dictated.

5.2.2 Progress Notes

5.2.2.1 The progress notes shall be legible and be sufficient to describe changes in the patient's condition, reasons for change of treatment and outcome of treatment and shall be written as frequently as the patient's condition warrants. In long term care facilities, progress notes shall be made upon each visit made by a Member.

5.2.3 Operative Notes

5.2.3.1 In elective or urgent surgical cases, the patient's history with a physical examination report and the signed operation consent shall be submitted to the booking clerk prior to the booking of the operation.

5.2.3.2 If such history and physical examination are not recorded before the time slated for operation, the operation shall be cancelled unless the Member states in writing that such delay would result in mortality or significant morbidity. Such cases shall be reviewed by the Regional Department of Surgery or other appropriate body of the Medical Staff at its next regular meeting.

5.2.3.3 A legible hand written note summarizing the operative procedure, the operative findings and complications, and post-operative orders must be placed on the chart prior to the patient leaving the post anaesthetic recovery unit.

5.2.3.4 Prior to any anaesthetic procedure, a pre-anaesthetic assessment must be recorded on the anaesthetic sheet by the anaesthetist. The anaesthetic record must be completed prior to the patient leaving the operating room or the post anaesthetic recovery unit.

5.2.3.5 All operations shall be described fully by the operating surgeon and dictated within twenty-four (24) hours of surgery.

5.2.4 Prenatal Record

5.2.4.1 The prenatal record is considered to be an integral part of the health record, and the information will be submitted in accordance with the British Columbia Reproductive Care Program Guidelines

5.2.5 Completion of Health Records

5.2.5.1 Health records (containing all relevant documents) should be completed (and validated by) all involved Members as soon as they become available from Health Records following discharge.

5.2.5.2 All health records must be completed according to policies that have been formally accepted by HAMAC and by the Board.

- 5.2.5.3 Prior to planned absences, the Member shall complete all incomplete outstanding patient records.
- 5.2.5.4 Records identified as incomplete during a planned absence of Member shall be completed within 14 days after that Member's return.
- 5.2.5.5 Members who have notified a Head of Department (local) or Regional Department Head in advance of their planned absence shall not be subject to sanction described in 5.2.5.8 for records identified as incomplete during their absence.
- 5.2.5.6 Members of the Locum Tenens staff are responsible for the completion of the health records of patients they have treated. The absent Member, upon return, is responsible for completion of records left incomplete by a covering Locum Tenens Member.
- 5.2.5.7 Written notification (sufficient to identify charts that are incomplete) of failure to complete records shall be provided to the responsible Member by the Health Records Department.
- 5.2.5.8 Within 14 days of issuance of this notice, the Member shall complete the records unless they have previously advised the Head of Department (local) or Regional Department Head of their absence. Outstanding records shall be completed within 14 days after the Member's return. Failure to do so may result in the automatic suspension of admitting and treatment privileges (see sec. 11.1 & 11.3 of the Bylaws) to practice in that facility (except for the ongoing care of patients already in hospital and on-call obligations) until the records are completed.
- 5.2.5.9 Should the records remain incomplete after 14 days, a 7-day advance notice of automatic suspension will be issued by couriered letter to the Member.
- 5.2.5.10 The Member whose privileges have been suspended must arrange the transfer of their patient's care (including MRP if necessary) to an appropriate Member consistent with sections 5.1.4 & 5.1.15 of the Rules.
- 5.2.5.11 Three (3) automatic suspensions for incomplete records during any 12-month period may result in a suspension of up to 30 days of all privileges following a review by the HAMAC.
- 5.2.5.12 Members whose privileges remain suspended more than 30 days will be reported to the BC College of Physicians & Surgeons.
- 5.2.5.13 A health record will be accepted for filing as "Incomplete" only under extenuating circumstances (extended Leave of Absence, Resignation, Retirement, Death) and only if the Member is unable to complete the records assigned. If the Member responsible is no longer available to complete the chart(s), the appropriate Department Site Lead or Division Head will be responsible for reviewing the record and providing written authorization for filing the health record as "Incomplete".

5.2.6 Ownership and Access

5.2.6.1 Health records are the property of the FHA and are not to be removed from the facility except as directed by management or ordered by the courts.

5.2.6.2 Confidentiality of patient information is paramount. Access to and copies of the health record or information contained therein must be strictly controlled with audit controls in place to track access and, aside from Members involved in the past or present care of the patient, can only be obtained by:

- The Coroner's office upon presentation of a warrant to seize
- Patient requests for their own record in accordance with FOIPP
- A court order, warrant, or subpoena
- Written patient authorization for release of information to third parties or as otherwise authorized in accordance with FOIPPA
- A written request by the patient's MRP for transfer of medical care accompanied by a release signed by the patient or the patient's next of kin/guardian if there is no previous record of that Member's involvement in care of the patient or of that Member being consulted by a known involved Member
- A request of the FHA Legal Counsel
- A written request of the College of Physicians and Surgeons of B.C., the College of Dental Surgeons of B.C., the College of Midwives of B.C., or the College of Registered Nurses of BC in accordance with applicable legislation
- A written request of a Regional Department Head, Program Medical Director or Vice President Medicine for purposes of review
- Members who are actively providing care to the patient
- Residents who are responsible to Members involved in the care of the patient
- Members carrying on a bona fide study of research upon application and approval by the Research Committee or other appropriate body
- Members or administration carrying out quality assurance, audits and utilization review upon application and signed approval of the Manager of Health Records under the sanction of the Board and subject to Section 51 of the Evidence Act, where applicable (i.e. should be members of designated Section 51 committees)

- Members / Residents seeking information from Health Records for the purposes of medical rounds and other educational purposes upon authorization from the appropriate Regional Department Head or Designate

5.2.7 Storage and Transfer of Records

- 5.2.7.1 Health records are to be retained in the Health Records Department unless otherwise approved by the CEO or Designate.
- 5.2.7.2 Whenever possible, a photocopy of the health records shall be made available rather than the original when the transfer of the health record is authorized under organizational policy, consistent with FOIPPA.

5.3 INFORMED CONSENT

- 5.3.1 Examination, treatment, procedure or operation) , other than in the case of an emergency which may be life, limb or organ threatening to the patient, may not be carried out on any patient unless a valid informed consent of the patient (or authorized decision maker) has been obtained, as per FHA policy and governing legislation.
- 5.3.2 The MRP or relevant Consultant is responsible for obtaining the informed consent of the patient prior to carrying out any medical care. Informed consent must be documented in accordance with FHA policy.
- 5.3.3 The FHA consent form and the procedures for obtaining consent from patients shall be developed in consultation with Medical Staff Leadership.

5.4 QUALITY IMPROVEMENT INFORMATION AND S. 51 OF THE EVIDENCE ACT

- 5.4.1 Access to quality assurance / improvement data for projects, research and preparation of publications, or administrative reasons shall comply with FHA policy regarding ownership and applicable legislation such as FOIPPA, and may be restricted under Section 51 of the *Evidence Act*.
- 5.4.2 Access by other personnel must be authorized by the chair of the appropriate committee in consultation with the CEO, and in accordance with FOIPPA and may be restricted under Section 51 of the *Evidence Act*.
- 5.4.3 All written communication between Medical Staff quality improvement committees shall be identified specifically as being for the purpose of the committees involved in order to preserve the protection of Section 51 of the *Evidence Act*.
- 5.4.4 In all circumstances, the communication of committee data shall avoid identifying the person or persons whose condition or treatment has been studied or reviewed and also avoid identifying the staff, Members and other personnel who were involved with the case.
- 5.4.5 Information gathered under Section 51 of the *Evidence Act* cannot be provided to individuals or organizations that request the information under FOIPPA.

5.5 EMERGENCY CARE

- 5.5.1 In an emergency, any Member is expected to provide Medical Care until a patient's MRP assumes responsibility.

5.6 MEDICAL ORDERS

- 5.6.1 All Members' orders for treatment shall be written and signed and must include the time and date of the order. Names should be printed or a stamp used under the signature to ensure legibility.
- 5.6.2 In an emergency, a Member may give verbal orders for treatment to a nurse, a respiratory therapist, a perfusionist, or a pharmacist, who shall transcribe the order onto the health record under the name of the Member per the writer's printed name and signature. Such orders should be countersigned by the Member or Designate
- 5.6.3 The Member who decides a patient requires admission shall provide orders necessary for the patient's care at the time of admission. Members are expected to comply with medication order policies.
- 5.6.4 Residents may write orders and prescribe controlled drugs according to the FHA's guidelines, developed in conjunction with UBC.

5.7 PRE-PRINTED ORDERS

- 5.7.1 A Regional Department may establish pre-printed orders for patients under the care of Members in the Regional Department. The appropriate Regional Department Head shall review and approve the pre-printed order in accordance with the regional standards approved by the Regional Medication and Therapeutics Committee. A Member must sign the pre-printed order for each patient under his/her care.

5.8 RESPONSIBILITY FOR PROVISION OF MEDICAL CARE OF PATIENT

- 5.8.1 Each MRP has a duty to ensure that their patient(s) is continuously under appropriate and available care either by themselves or by a designated Member.
- 5.8.2 The Regional Department and/or Regional Division shall ensure that a Medical Staff Member is available to provide care twenty-four (24) hours per day, seven (7) days per week for new patient referrals.
- 5.8.3 Each Regional Department and/or Regional Division shall ensure a rotation of Members to provide emergency coverage at all times and shall routinely provide a list of such rotation to the Emergency Departments and the switchboard. The call list and any changes shall be entered in the electronic on call system on the FHA intranet which shall be up to date at all times. In the case of specialist Regional Departments and Regional Divisions, this coverage must be by appropriately qualified specialists. The list must be updated as changes occur.
 - 5.8.3.1 It is understood that in some smaller facilities, provision for an on-call rota will not be possible unless there is collaboration with

Regional Departments in other nearby facilities to provide the coverage.

- 5.8.3.2 When a Regional Department includes Members whose practices are sufficiently distinct from those of other Members, either by reason of specialty of practice or by geographic distinction, as to preclude participation by all Members in a common on-call rota covering the practices of all Members, the Regional Department shall designate separate on-call rotas to assure the continuous availability of on-call services for the appropriate groupings of practices within the same maximum on call frequency.
- 5.8.3.3 When a Consultant has participated in the care of an inpatient as per College requirements, that Consultant must continue to be available to respond to care needs arising for that patient or must specify another qualified and privileged Consultant to be available for any period that they themselves are not available.
- 5.8.4 Where Members share a common clinical specialty practice in different communities, a common on-call rota may be established by the Regional Departments, provided that a clinical service delivery model is established to ensure that patients have access to the on-call Member as necessary.
- 5.8.5 All Members shall participate equitably in Regional Departmental on-call rosters, including weekend call rosters, except in special circumstances as approved by the Regional Department Head and HAMAC.
- 5.8.6 The facility or community resources assigned to a member should be reduced proportionately with the reduction of call responsibilities unless there is agreement between Members of the Regional Department not to enact this article.
- 5.8.7 Members will be expected to maintain acceptable levels of availability when on-call. Members may not limit their availability on call to day-time only but must be available for the 24 hours of their assigned day on call. Those Regional Departments which deal with life/limb/organ threatening emergencies shall delineate the method of obtaining assistance when the first Member of the medical staff on-call cannot respond within these timeframes.
- 5.8.8 Additionally, Members may enter into contractual arrangements with the FHA for the provision of availability to respond to the emergent care needs of new and unassigned patients within contractually defined anticipated response times. Such contracts do not supersede the ethical and professional responsibilities of Members. Members may, for the sake of expediency, fulfill their Regional Departmental on-call responsibilities concurrently with their contracted availability.
 - 5.8.8.1 Remuneration for on-call availability shall be based on a contract with FHA and shall be in accordance with contractual rates for on-call availability as may be established from time to time through the negotiation of a provincial medical on call availability program.

5.9 POST-OPERATIVE/POST PROCEDURAL CARE

- 5.9.1 Post-Operative or post procedural care is the responsibility of the Member (including the anaesthetist if relevant) who performed the intervention unless an alternate responsible Member(s) is/are identified on the order sheet and on an information sheet provided to the patient at the time of discharge, including discharge from Daycare Surgery.

5.10 DELEGATED FUNCTIONS

- 5.10.1 Members may delegate certain functions that have been approved by senior management. Medical functions may be delegated to a variety of health professionals following the process outlined below.
- 5.10.2 A delegated medical function is a medical act that, with the agreement of the relevant Regional Department, has been formally transferred to another health care professional, in the interest of good patient care and efficient use of health care resources. The process of delegation to other health professionals must be consistent with the *Health Professions Act*.

5.11 ORGAN DONATION AND RETRIEVAL

- 5.11.1 Appointment and Privileges
- 5.11.1.1 A temporary appointment and temporary privileges may be granted consistent with the sec 4.1.4 of Bylaws and s. 3.5 of the Rules.
- 5.11.2 Transfer of Responsibility
- 5.11.2.1 In the event of possible organ donation, responsibility for the physiological maintenance of the organ donor after the declaration of neurological death may be transferred, at the discretion of the MRP to a member of the Organ Retrieval Team.
- 5.11.3 Consultation
- 5.11.3.1 In the declaration of neurological death for organ donation, consultation shall be held with a neurosurgeon or neurologist, or the Member representing the highest level of neurological skills available at the facility if no neurosurgeon or neurologist is on staff or readily available.
- 5.11.4 Identification of Potential Donors
- 5.11.4.1 In accordance with the *Human Tissue Gift Act* Regulations, all deaths or impending deaths of infants thirty-nine (39) weeks or more, children and adults up to and including seventy-five (75) years must be reported to the BC Transplant Society (BCTS) for the determination of medical suitability for organ donation. The determination of appropriateness for organ donation will be done by BCTS in conjunction with the referring Physician. All ventilated patients with an impending or determined diagnosis of brain death will be evaluated as potential solid organ donors, and those individuals who have had a cardiac death will be evaluated as potential donors for corneas and tissue.

- 5.11.5 Designated Requestor
 - 5.11.5.1 If the BCTS determines the patient is medically suitable for organ, cornea or tissue donation, then the approach for consent of the family will be made by a designated requestor specifically trained in accordance with BCTS policy, usually a Member, nurse, social worker or other trained individual.
- 5.11.6 Consent
 - 5.11.6.1 Written consent for organ donation shall be obtained from the next of kin by a Member, or, if requested and logistically possible, by a Member of the Organ Retrieval Team. Consent shall be obtained from the next of kin after the declaration of neurological death. Consent must be documented on the appropriate consent form. Telephone consent requires two witnesses (a Member or nurse).
 - 5.11.6.2 In the event of eye and/or tissue donation only, after cardiac death, consent shall be obtained from the next of kin after cardiac death, by a Member of the medical staff, or an employee of the Eye Bank or the Tissue Bank of British Columbia. Consent must be documented on the appropriate consent form.
- 5.11.7 Medical Orders
 - 5.11.7.1 In the case of organ donation, after the declaration of brain death, and in the event that the MRP has transferred responsibility of care to the Organ Retrieval Team, standing orders (available from the Organ Retrieval Team) may be followed, and verbal orders may be given to a nurse or a respiratory therapist for the physiological maintenance of the donor. Any deviation from standing orders protocol will be discussed in consultation with the MRP or Consultant.
- 5.11.8 Pronouncement of death
 - 5.11.8.1 In the case of organ donation, the criteria for the diagnosis of neurological death published by the Canadian Council for Donation and Transplantation (2003), will be followed in accordance with the Human Tissue Gift Act, Part 2, Section 7.

5.12 INFANT AND MATERNAL TRANSPORT TEAMS

- 5.12.1 The MRP may transfer responsibility to a Member of the Transport Team for the physiological maintenance of the patient while the patient remains under care within the facility. As the MRP caring for the patient, the Transport Team is authorized to give verbal orders to a nurse or respiratory therapist to ensure optimal physiological maintenance of the patient during preparation for transport.

5.13 PRONOUNCEMENT OF DEATH, AUTOPSY AND PATHOLOGY

- 5.13.1 A physician or, if a physician order is documented in the case of an expected death, a designate must pronounce death.

- 5.13.2 No autopsy shall be performed without order of the Coroner or written consent of the appropriate relative or legally authorized agent of the patient on the appropriate consent form.
- 5.13.3 Where autopsy is appropriate, the MRP or Consultant shall make all reasonable efforts to obtain permission for the performance of an autopsy.
- 5.13.4 All tissue or material of diagnostic value shall be sent to the Department of Pathology / Laboratory Medicine for examination, storage, and/or disposal.
- 5.13.5 Pathology specimens including body tissues, organs, materials, and foreign bodies shall not be released to any agency or person without due authorization of the Regional Department Head of Lab Medicine and Pathology or Member of the Department.
- 5.13.6 The MRP shall comply with the Vital Statistics Act concerning the completion of the medical certificate of death or the medical certificate of stillbirth.
- 5.13.7 Unanticipated deaths shall be reported to the Coroner in accordance with the requirements of the Coroner's Act.

5.14 ACCREDITATION AND QUALITY MANAGEMENT

- 5.14.1 The Medical Staff shall be actively involved in FHA's ongoing assessment of quality of its programs and services and patient safety in relation to all aspects of medical services provided within the organization's jurisdiction
- 5.14.2 All Members of the Medical Staff will participate in QI activities including, but not limited to, utilization management, critical incident reviews, mortality and morbidity rounds and specific departmental or regional program related activities as required by the Hospital Act Regulation and requested by the Regional Department Head of their Primary Department or Regional Division Head.

5.15 VACCINATIONS FOR COMMUNICABLE DISEASES

5.15.1 **Vaccinations Required:**

- 5.15.1.1 ***Pertussis*** - Members will receive an adult pertussis booster each ten years. Proof of vaccination will be required
- 5.15.1.2 ***Measles Mumps Rubella (MMR)*** - Members born after 1957 will have two lifetime doses of MMR vaccine. Those born before or during 1957 will rely on immunity gained through disease exposure.
- 5.15.1.3 ***Influenza*** - a vaccination record must be obtained each season.

5.15.2 **Principles:**

- 5.15.2.1 Members of the Medical Staff should maintain up to date vaccinations for those communicable diseases which can be transmitted from a health care worker to a patient in the course of normal patient care activities.
- 5.15.2.2 All vaccinations must be completed according to policies that have been formally accepted by HAMAC and by the Board.

5.15.2.3 Vaccinations against seasonal pathogens must be obtained within 30 days of the commencement of the vaccination period.

5.15.2.4 Vaccinations providing long term protection against respiratory pathogens must be obtained within six months of notification of the requirement by the Office of the Chief Medical Health Officer via HAMAC.

5.15.3 **Procedure:**

5.15.3.1 Members of the Medical Staff must provide evidence of vaccination to FHA Workplace Health within 14 days of a request to do so. Verbal advice as to the time and place of vaccination will be acceptable.

5.15.3.2 Members may be excused compliance with vaccinations (**except** pertussis and MMR vaccinations) under the following circumstances:

- Leave of Absence
- Resignation
- Retirement
- Moral, ideological or religious objections
- Medical Reasons
- Absence During infectious period
- Agreement to adopt alternative infection control measure(s) which protect the patient. These measure(s) must be acceptable to HAMAC or its delegate. HAMAC may require the Member to participate in a reasonable orientation program that educates the member on the proper use of the alternative infection control measure(s).

5.15.3.3 Members who have notified a Head of Department (local) or Regional Department Head in advance of their planned absence for the duration of the infectious period of a seasonal pathogen shall not be subject to sanction described in 5.15.3.7 for vaccinations identified as incomplete during their absence.

5.15.3.4 At the end of the 30 day period (5.15.2.3) evidence of vaccination shall be provided to Occupational Health by the Member.

5.15.3.5 Any Member not providing evidence of vaccination within the 30 day period to Workplace Health will be contacted by Workplace Health and advised of the need for vaccination.

5.15.3.6 Within 14 days of being contacted by Workplace Health. The Member shall complete the vaccination and provide written evidence of same.

5.15.3.7 Should the vaccination remain incomplete after the 14 days, a 7-day advance notice of automatic suspension (consistent with

article 11.2.1.1 of the Bylaws) will be issued to the Member by the CEO or VP Medicine via couriered letter.

- 5.15.3.8 Provision of written evidence of vaccination to Workplace Health will cancel the advance notice of suspension or the suspension.
- 5.15.3.9 The Member whose privileges have been suspended must arrange the transfer of their patient's care (including MRP if necessary) to an appropriate Member consistent with section 5.1.4 & 5.1.15 of the Rules.
- 5.15.3.10 Members whose privileges remain suspended more than 30 days will be reported to the Member's licensing body.
- 5.15.3.11 Three (3) automatic suspensions for incomplete vaccinations during any 36-month period may result in a suspension of up to 30 days of all privileges following a review by the HAMAC.

ARTICLE 6 – DISCIPLINE AND APPEAL

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

ARTICLE 7 – THE MEDICAL STAFF ASSOCIATION

The Medical Staff Association of the FHA shall consist of all Members. The Medical Staff Association may be subdivided at the level of individual facilities or community programs. The operation and structure of the Medical Staff Association shall be in accordance with the Rules as approved and adopted by its members.

7.1 PURPOSE

- 7.1.1 The objectives of the Medical Staff Association include the promotion and advancement of Member involvement in the provision of the organization's medical services and to represent and advocate for the interests of the Medical Staff.
- 7.1.2 The operation and structure of the Medical Staff Association shall be in accordance with the Rules as approved and adopted by its members.

7.2 ELECTED OFFICERS OF THE MEDICAL STAFF ASSOCIATION

- 7.2.1 Each facility (or community program) shall have elected officers of the Medical Staff Association.
- 7.2.2 The elected officers of the Medical Staff Association of each facility shall be the:
 - President
 - Vice-President (may not be required at all sites)
 - Secretary Treasurer

- 7.2.3 All elected officers shall all be Members.
- 7.2.4 The elected officers of the Medical Staff Association shall be responsible for:
- meetings – Regular, Annual and Special
 - appointing special subcommittees as needed

7.3 ELECTION PROCEDURE

- 7.3.1 A slate of nominated officers will be proposed by a committee constituted for this purpose; consisting of the immediate Past President of the Medical Staff Association (Chair) and two other members to be appointed by the elected officers of the Medical Staff Association.
- 7.3.2 The elected officers of the Medical Staff Association shall be elected at an annual meeting of the Medical Staff and shall hold office for a period of two (2) years. Officers may hold office for up to three (3) consecutive terms.
- 7.3.3 The elections shall be by acclamation or by a majority vote by all Active Members present and eligible to vote and casting ballots.

7.4 DUTIES OF THE PRESIDENT OF THE MEDICAL STAFF ASSOCIATION

The President of the Medical Staff Association shall:

- convene and chair all meetings of the general Medical Staff
- be a voting member of all committees of the Medical Staff of the facility
- receive information as deemed appropriate from the HAMAC, regional programs, the Board, the CEO, FHA or site senior management, the Program Medical Directors, the Regional Department Heads or others and disseminate this information to the Medical Staff and local community physicians
- communicate all recommendations and matters of concern from the Medical Staff to the Program Medical Directors, the Regional Department Heads and/or the VP Medicine, HAMAC, the Presidents' Council (established under Article 7.8) and the FHA senior management as appropriate
- attend the Presidents' Council
- represent the collective interests of Members
- in the case of disciplinary action taken with respect to an individual member, inform that member of their rights under the FHA Bylaws.

7.5 DUTIES OF THE VICE-PRESIDENT OF THE MEDICAL STAFF ASSOCIATION

The Vice President of the Medical Staff, in the absence of the President or inability of the President to perform the duties of that office, shall assume all the duties and authorities of the President.

7.6 DUTIES OF THE SECRETARY-TREASURER OF THE MEDICAL STAFF ASSOCIATION

The Secretary-Treasurer shall

- give notice and keep minutes of all meetings of the Medical Staff
- attend to all correspondence of the Medical Staff Association
- cause a financial statement of the Medical Staff Association funds to be prepared for presentation to the annual meeting, and ensure that an audit of the Medical Staff Association funds is conducted annually
- perform such other duties pertaining to the office of the Secretary-Treasurer as may be required, including assumption of the duties and authorities of the Vice-President in the absence of the Vice-President or inability of the Vice-President to perform the duties of that office.

7.7 DUTIES OF THE PAST PRESIDENT OF THE MEDICAL STAFF ASSOCIATION

The Past President of the Medical Staff Association shall serve in an advisory capacity, along with the President of the Medical Staff Association, VP, and Secretary-Treasurer.

7.8 PRESIDENTS' COUNCIL

- 7.8.1 The Presidents' Council (composed of all Presidents of Medical Staff Association at each facility and the Presidents of community medical staff associations) shall meet quarterly or at the call of their chair to discuss issues pertinent to the Medical Staff.
- 7.8.2 A President of the Presidents' Council shall be elected by the Presidents' Council.
- 7.8.3 The President of the Presidents' Council, or delegate, shall be a Member of the HAMAC.

7.9 RECALL, REMOVAL AND FILLING OF VACANT OFFICES

- 7.9.1 Elected officers of the Medical Staff Association may be recalled and removed in accordance with the following:
- Upon receipt of a petition seeking recall of an elected officer, signed by one third of Members eligible to vote, the President shall call a special meeting of the Medical Staff to be held within thirty (30) days of receipt of the petition. In the case of recall of the President, the Past President shall call and chair this meeting. If at this meeting, with a quorum present, two-thirds of eligible voters present vote in favour of recall the office shall be declared vacant. An election for the vacant office may be held at the same meeting.
 - In the event of death, removal or resignation of an elected officer during the term of office, another Member may be elected at a regular or special meeting to fill the balance of the expired term. Otherwise, the duties of

that office shall be assumed by the remaining officers as specified in the duties of the officers.

- In the event of simultaneous removal or resignation of the entire elected officers of the Medical Staff Association, the Past President of the Medical Staff Association shall assume the duties and responsibilities of the President of the Medical Staff Association, will handle all urgent matters, and will immediately call an election for the vacant offices.

ARTICLE 8 – MEETINGS OF THE MEDICAL STAFF ASSOCIATION

All meetings of the Medical Staff Association shall be conducted according to Robert's Rules of Order, newly revised. Records of all meetings shall be kept.

8.1 ANNUAL MEETING

- 8.1.1 The annual meeting shall be the last meeting of each Year at which time elections shall be held for positions of officers whose terms are expiring.
- 8.1.2 The President shall post a notice for members of the Medical Staff Association at least ten (10) days prior to the annual meeting announcing the time and place of the meeting.
- 8.1.3 An annual report from the officers and committees of the Medical Staff Association shall be presented in writing.
- 8.1.4 Representatives from the site senior administration shall be invited to attend.
- 8.1.5 Representatives from the Board may be invited to attend.

8.2 REGULAR MEETINGS

- 8.2.1 Regular meetings of the Medical Staff Association shall be held at least two (2) times a Year, in addition to the Annual Meeting, or more frequently as deemed appropriate by the President or officers of the Medical Staff Association.
- 8.2.2 The President shall post a notice for members of the Medical Staff Association at least ten (10) days prior to a regular meeting announcing the time and place of the meeting.
- 8.2.3 The CEO and the Vice President Medicine shall be given notice of the meeting and they or their delegates may attend all meetings of the Medical Staff Association.
- 8.2.4 The business of regular meetings shall include informing the Medical Staff Association of actions recommended by HAMAC. The chair of HAMAC, or his delegate, may be invited to attend the meeting.
- 8.2.5 Regional Department and committee reports may be presented at these meetings.

8.3 SPECIAL MEETINGS

- 8.3.1 A special meeting may be called at the sole discretion of the President of the Medical Staff Association for whatever reason including at the request of the Board, CEO or HAMAC. A special meeting shall be called by the President of the facility Medical Staff Association at the request of one-third of the facility's eligible voting members of the Medical Staff and shall be held within fourteen (14) days of receipt of the request.
- 8.3.2 At a special meeting, no business shall be transacted except as explicitly stated in the notice calling the meeting.
- 8.3.3 Notice shall be posted by the President at least five (5) business days before the special meeting and shall contain the purpose of the meeting.
- 8.3.4 No regular business shall be transacted at a special meeting.

8.4 ATTENDANCE

- 8.4.1 Active and Provisional Staff Members shall attend at least 50% of the general Medical Staff Association meetings in a calendar year.

8.5 QUORUM

- 8.5.1 Each facility or community Program should establish a quorum for their Medical Staff Association meetings. The quorum should be a minimum of 50% of the members of the Active Staff eligible to vote.

8.6 MEMBERSHIP DUES

- 8.6.1 Each Member of the Active and Provisional Staff shall pay an annual membership fee at the Primary Site of the Member, as determined by a simple majority of Members in attendance at the annual meeting on recommendation of the elected officers of the Medical Staff Association. This annual fee is due and payable each Year and is a requirement in order to remain on the Medical Staff.

ARTICLE 9 – AMENDMENTS

- 9.1 The Board, upon the recommendation of HAMAC may make amendments to the Rules.
- 9.2 The Medical Staff shall be provided with any and all proposed amendments and afforded the opportunity to discuss and consult on any proposed amendments prior to the proposed amendments being forwarded to the Board for a final decision. The Board will be informed of the results of the consultation with the Medical Staff prior to making a final decision. The results of any vote taken by the Medical Staff in response to such a consultation shall be forwarded to the Board via the HAMAC. The amended Rules become effective when adopted by the Board.
- 9.3 The Rules shall be reviewed and amended periodically as necessary to maintain consistency with the Medical Staff organization structure and with provincial legislative and regulatory changes.

- 9.4 The Rules shall be reviewed no less frequently than every three years, revised as necessary and dated accordingly.

ARTICLE 10 – APPROVAL OF RULES

THIS IS TO CERTIFY:

Amendments to the Rules were recommended by the Fraser Health Authority Medical Advisory Committee on February 13, 2013.

Signed by:



Dr. Peter Doris
Chair, FHA Medical Advisory Committee



Dr. Nigel Murray
Chief Executive Officer, FHA

The Rules were adopted by the Fraser Health Authority Board of Directors on May 16, 2013.



David Mitchell
Chair, Fraser Health Authority Board of Directors

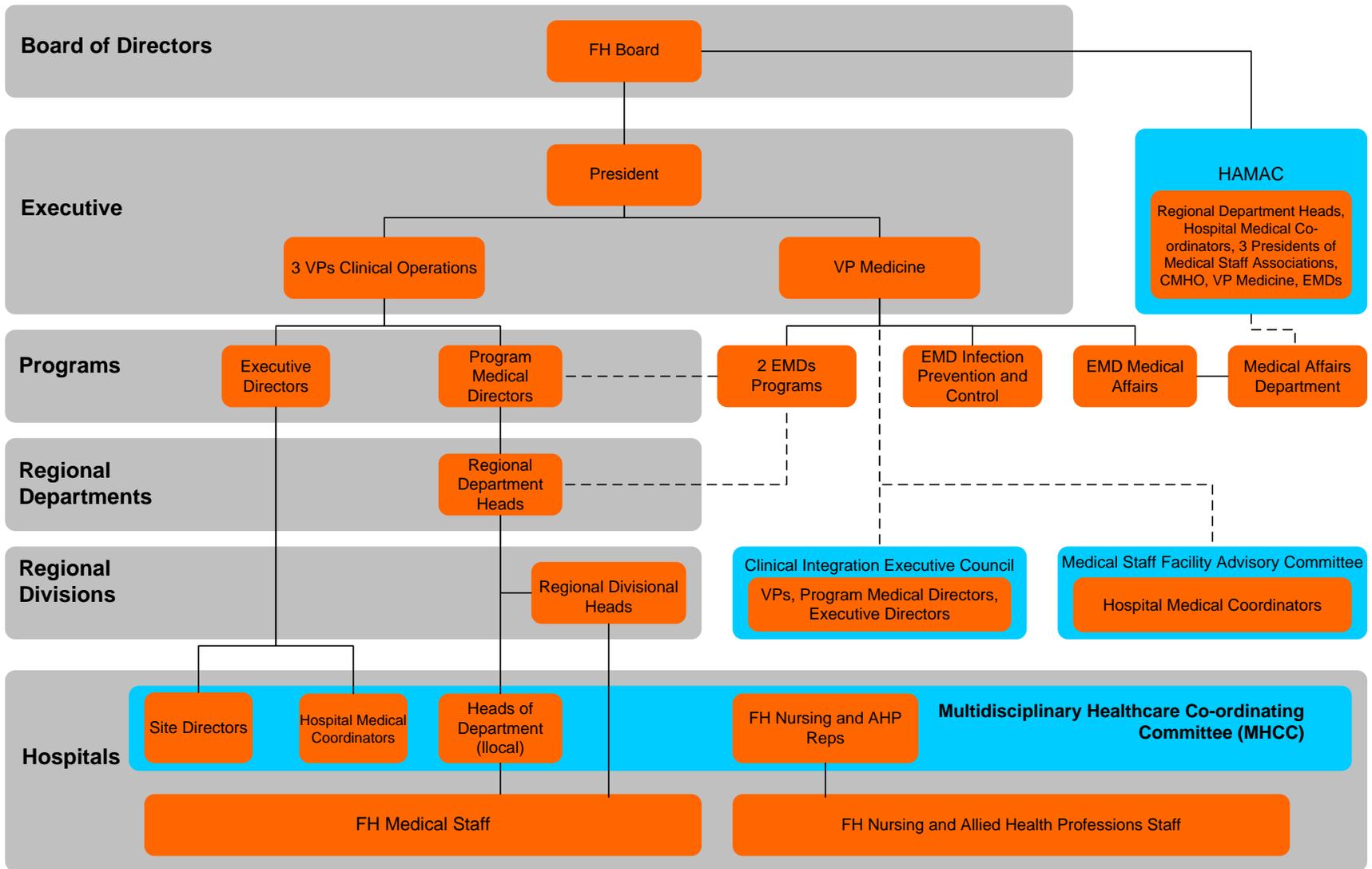
APPENDIX 1 – THE STRUCTURE OF MEDICAL LEADERSHIP AT FRASER HEALTH AUTHORITY

The various leadership roles within the organizational charts below are described within the Rules.

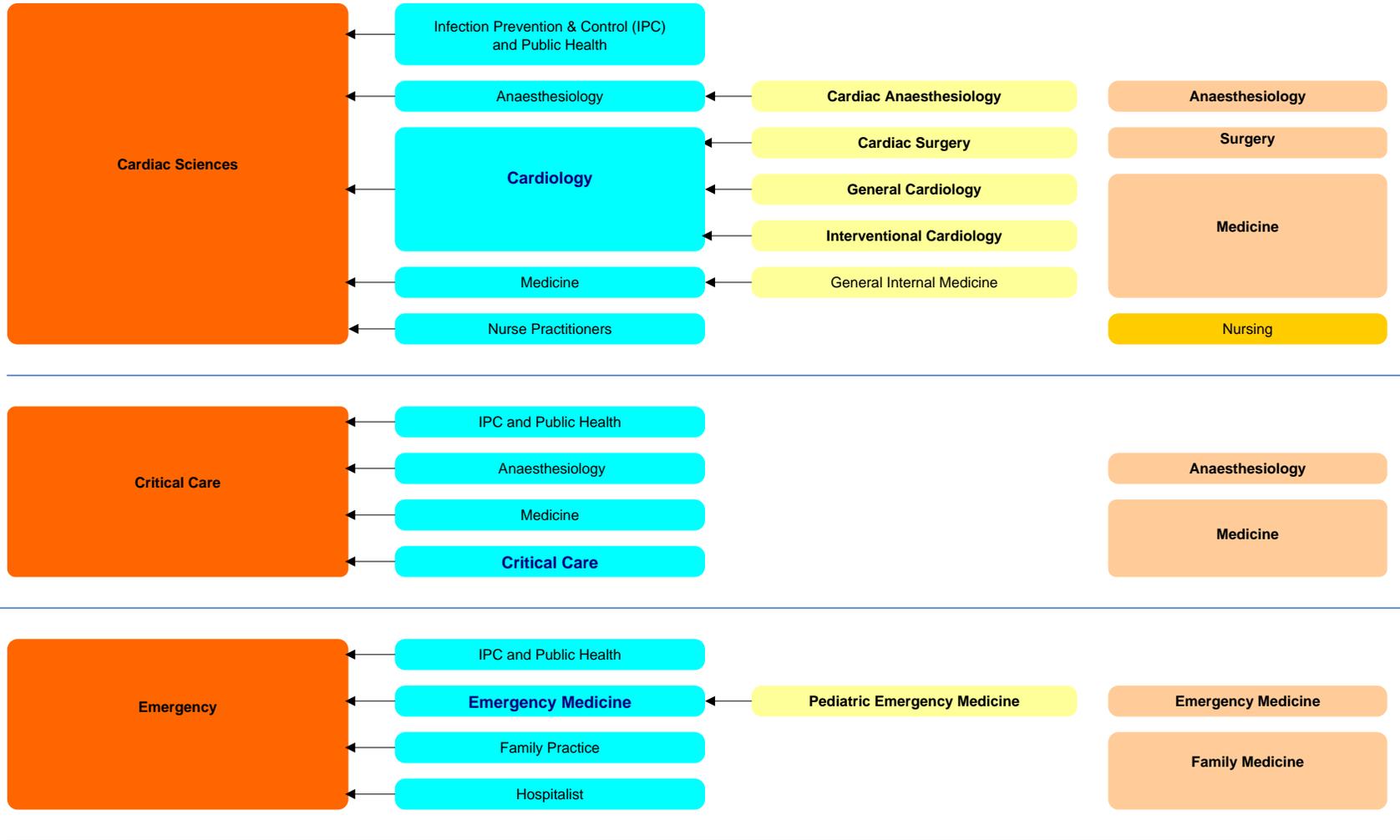
Medical Leadership complements and parallels the administrative leadership within the Programs. Program Medical Directors and (Program) Executive Directors are jointly accountable to the VP Clinical Operations. The Program Medical Directors and Regional Department Heads have professional accountability through the EMDs to the Vice President Medicine.

The following organizational charts show, for each Program, the accountabilities of Regional Division Heads and Regional Department Heads within Programs. Each Regional Department has a primary relationship to a Program. Because each Program may relate to more than one Regional Department, and vice versa, the Regional Division Heads and Regional Department Heads may have a relationship with a Regional Department or Program outside of their primary accountability. Regional Departments and Divisions are shown in boldface where they have their primary relationship with a Program and Regional Department.

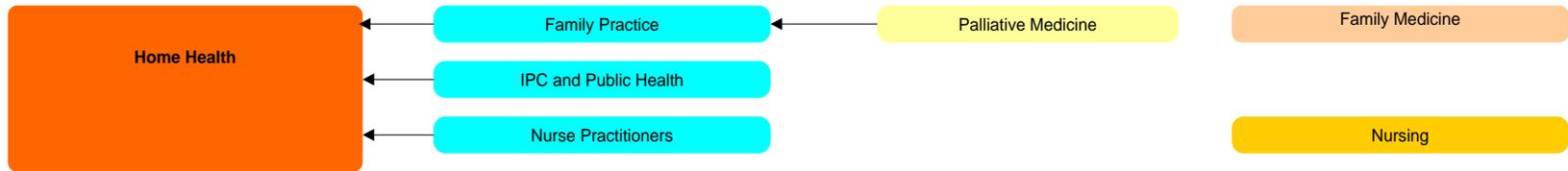
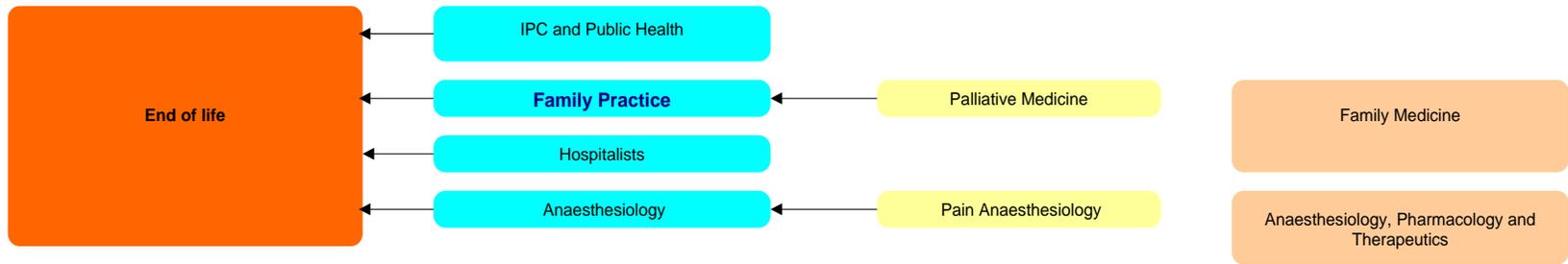
The organizational charts also map the relationships of Regional Departments to Academic Departments at UBC.

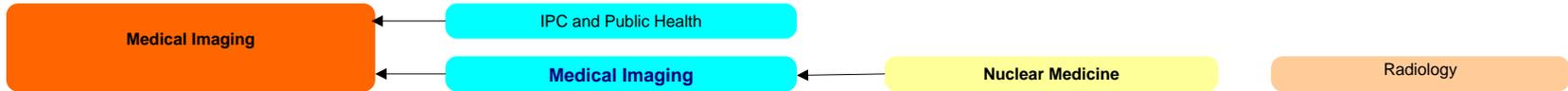
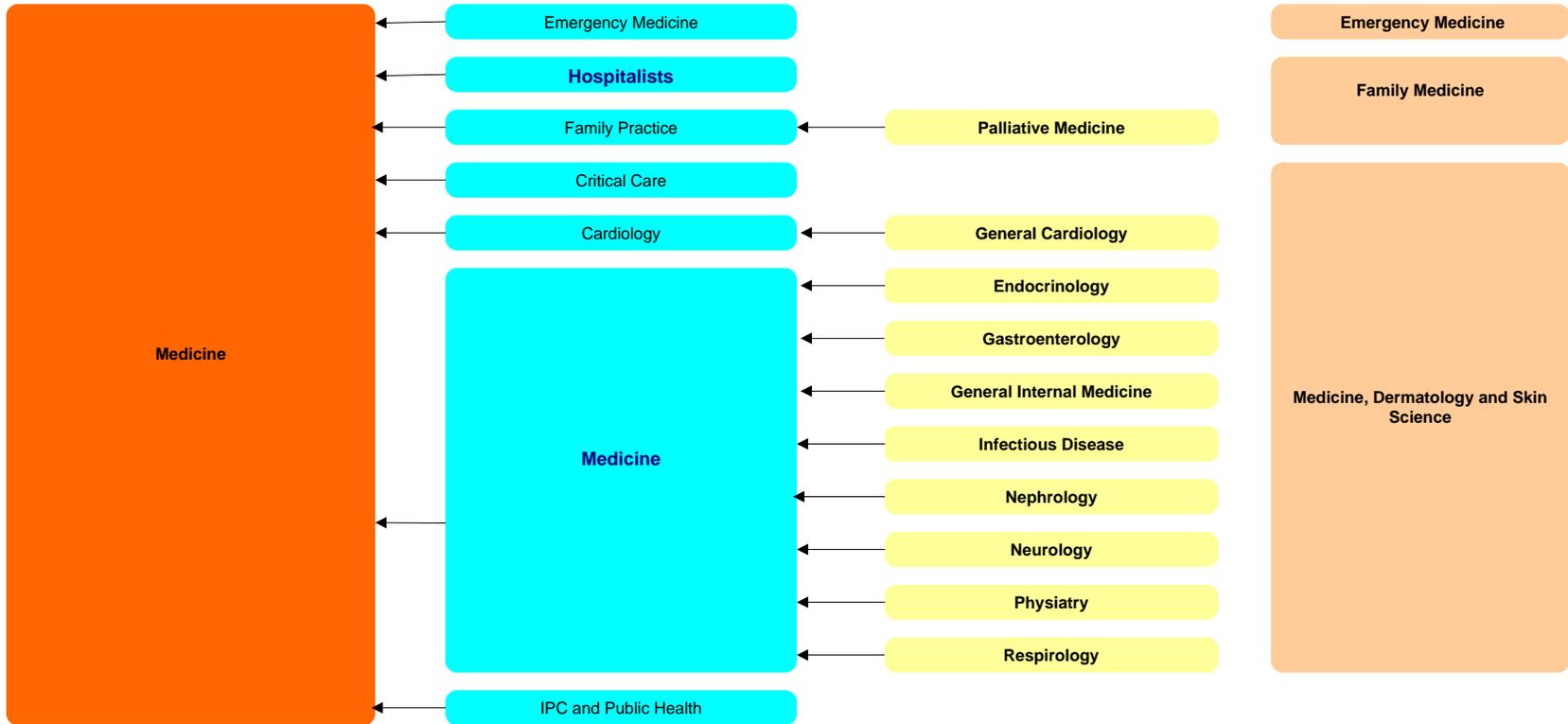


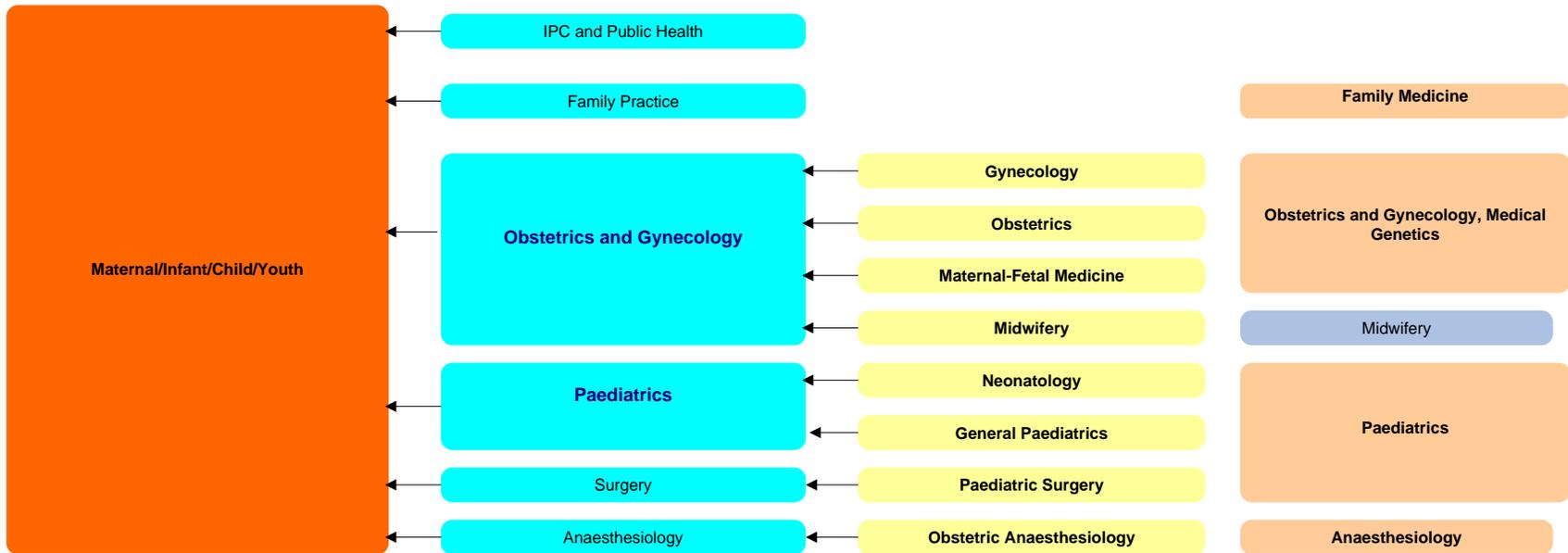
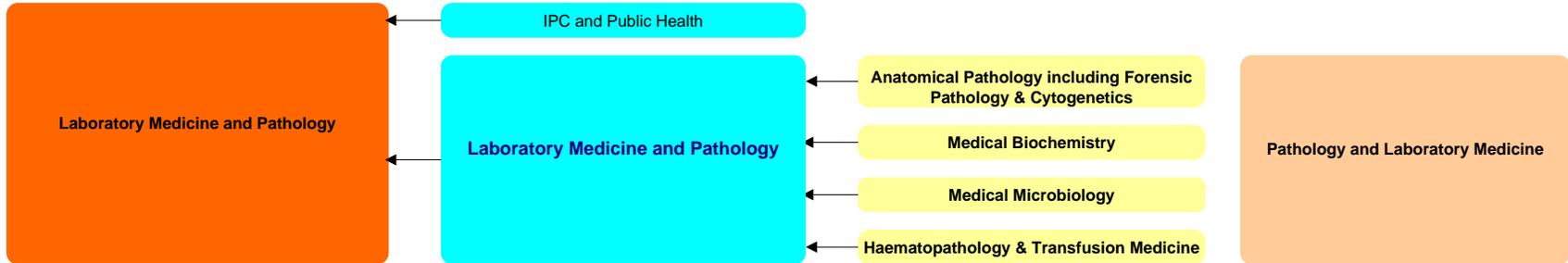
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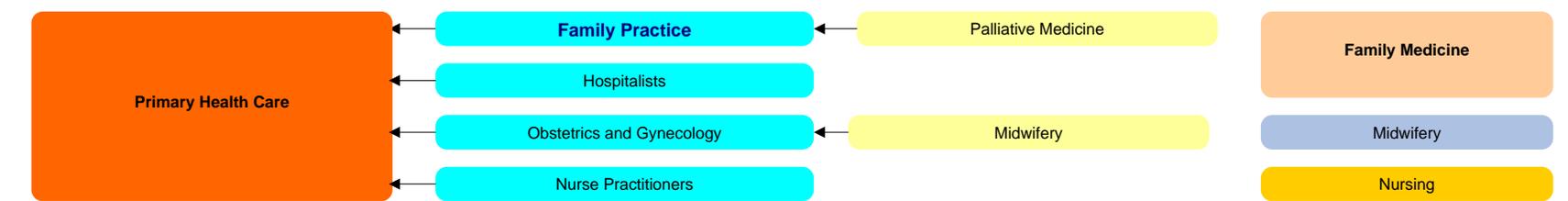
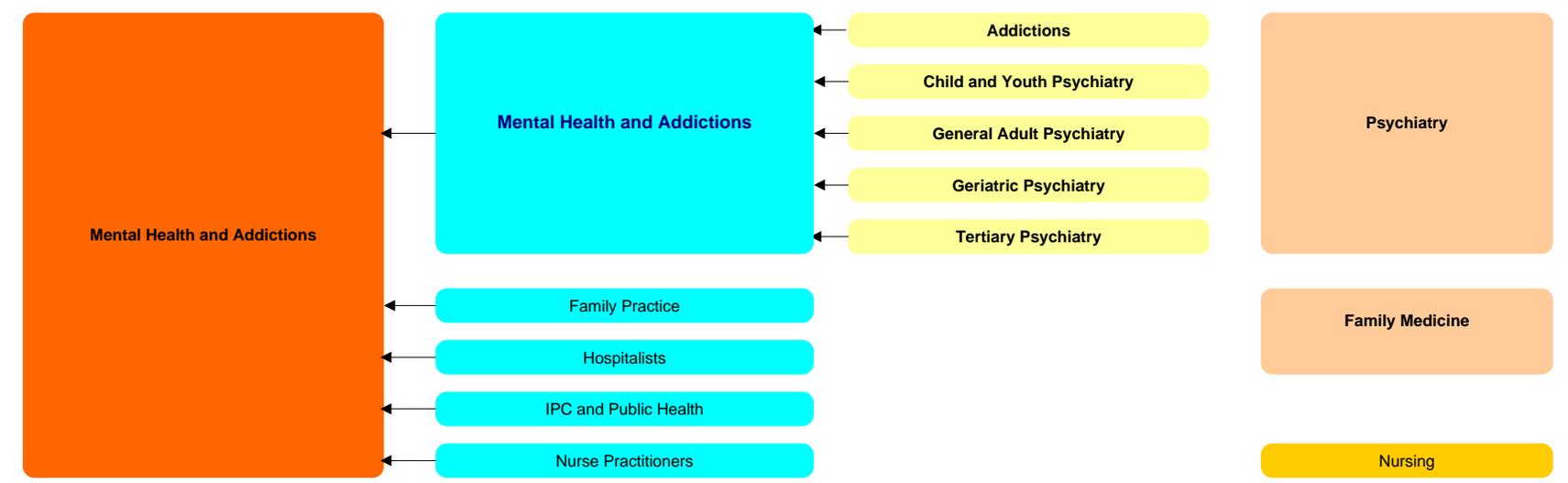
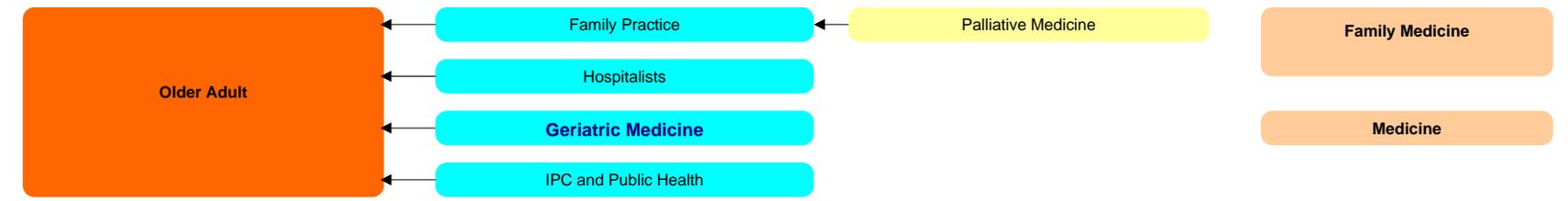


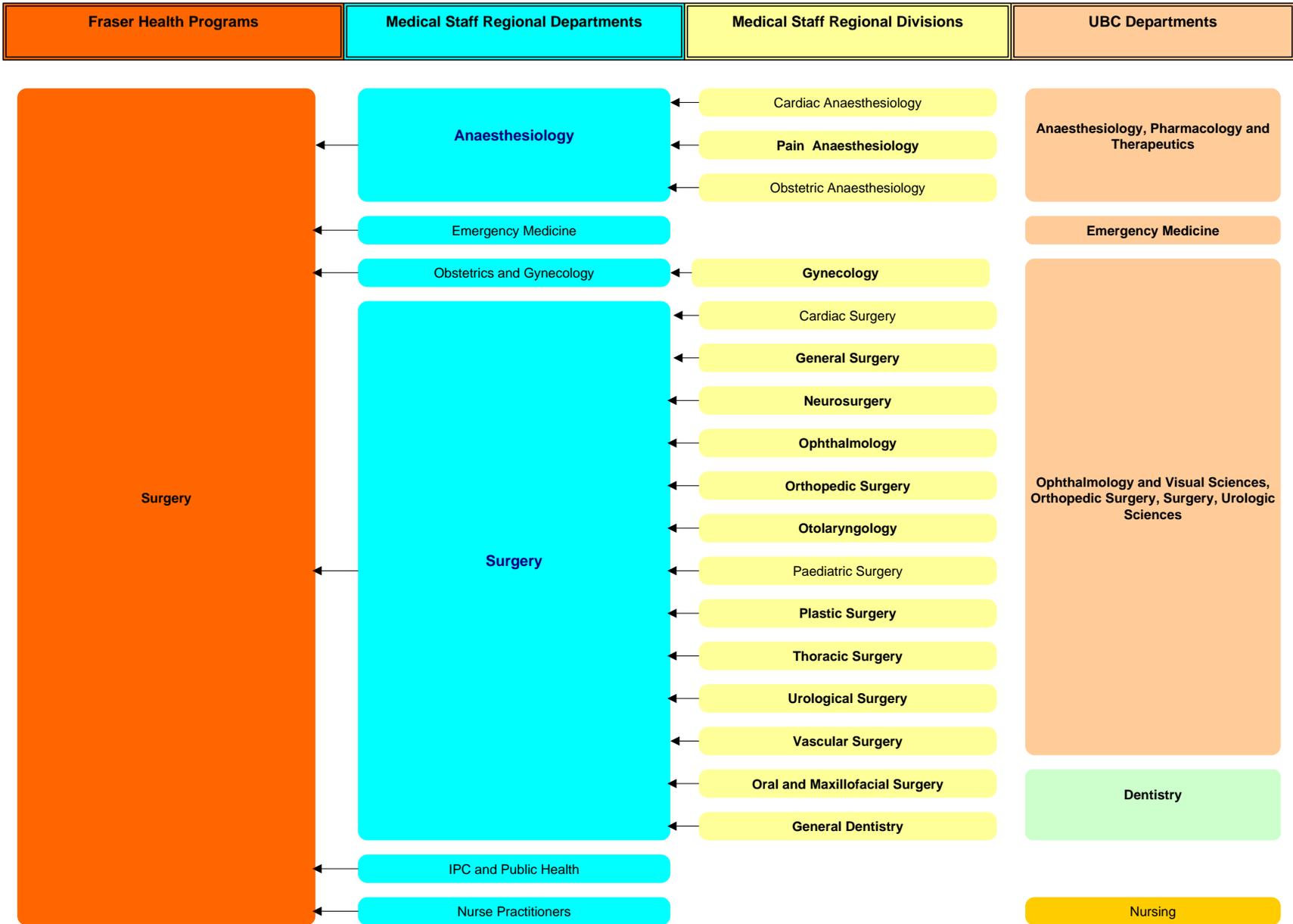
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APPENDIX 2 – ORIENTATION AND REFRESHER PROGRAM

The purpose of orientation is to ensure Members are provided with relevant information and training to support them in their provision of safe care in partnership with FHA. The Orientation and Refresher Program is online on the Physician Website:

Orientation Online:

http://physicians.fraserhealth.ca/orientation_and_organization/orientation_program/

The Orientation Program must be completed in order for a member of the Provisional category to be promoted to the Active Category.

APPENDIX 3 – REQUIREMENTS FOR IN DEPTH PERFORMANCE EVALUATION OF MEDICAL STAFF MEMBERS

Not available.

APPENDIX 4 – TERMS OF REFERENCE OF MEDICAL COMMITTEES

http://physicians.fraserhealth.ca/orientation_and_organization/hamac/medical-committees/