Hôtel-Dieu Grace Healthcare
CHANGING LIVES TOGETHER

PROFESSIONAL STAFF

Rules and Regulations

Recommended by the Medical Advisory Committee – [January 7th, 2018]
Approved by the Board of Directors - [January 24, 2018]

TABLE OF CONTENTS

Article 7 – Reporting of Changes to Status

Article 8 – Leaves of Absence

Article 9 – Patient Admissions and Discharges

Article 10 – Continuity of Medical Coverage

Article 11 – Documentation

ARTICLE 1: OVERVIEW

CONTENTS

1.1 Definitions and Interpretation

These Rules and Regulations shall be interpreted in accordance with the definitions and rules of interpretation set out in the Definitions and Interpretation Schedule. With the exception of "patient," defined terms are capitalized.

1.2 Introduction

The Hospital has a unique role in the Windsor-Essex region, as the provider of all non-acute care services. These services are managed within the following three "Programs":[1]

(a) the Restorative Care Program;
(b) the Mental Health & Addictions Program; and
(c) the Consult Service Program.

Each Program has both a program medical director, as well as a program administrative director. The Restorative Care and Mental Health & Addictions Programs are broken down into sub-units, with a clinical lead for each sub-unit. The Consult Service Program is under the oversight of the Chief of Staff.

1.3 Legal Context

These Rules and Regulations are part of a larger legal framework, including, in order of hierarchy: the law of the land;[2] the letters patent;[3] the By-laws, consisting of the Professional Staff By-law containing provisions relating to the organization and duties of the Professional Staff, and the Administrative By-law containing provisions relating to corporate management and administration; Board policies; operational policies and

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1 See section 7.1 of the Professional Staff By-laws which establishes the Hospital Programs.

2 The law of the land includes both statutory law and common law (judge made law). The *Public Hospitals Act (Ontario)* and its regulations are particularly important in this context.

3 The Letters Patent is the charter or constitution for the Corporation – the document that brought the Corporation into existence. The Corporation was incorporated April 12, 1917. Letters Patent of Continuation were issued June 15, 2012, which among other things, changed the name of the Corporation from, "The Religious Hospitallers of Hotel Dieu of St. Joseph of the Diocese of London" to, "Hôtel-Dieu Grace Hospital, Windsor". Supplementary Letters Patent were issued October 15, 2013, changing the name of the Corporation from, "Hôtel-Dieu Grace Hospital, Windsor" to, "Hôtel-Dieu Grace Healthcare".

contractual obligations, including for example, the Affiliation Agreement. These Rules and Regulations are subordinate to the law of the land, the letters patent and By-laws.

More specifically, the *Public Hospitals Act (Ontario) Regulation 965* mandates the Medical Advisory Committee to, among other things, make recommendations to the Board concerning, "the clinical and general rules respecting the medical, dental … staff, as may be necessary in the circumstances."[4] The By-laws further reflect this obligation.[5] These Rules and Regulations are made pursuant to the *Public Hospitals Act (Ontario) Regulation 965* and the By-laws. They have been recommended by the Medical Advisory Committee and approved by the Board.

1.4 Purpose of Rules and Regulations

These Rules and Regulations exist to:

(a) **Clarify Expectations.** Clarify what is expected of the Professional Staff, insofar as their practice and professional conduct at the Hospital.

(b) **Professional Staff Resource.** Serve as a resource to support effective patient care by the Professional Staff.

(c) **Commitment.** Reflect the Professional Staff's commitment to safe and effective patient care.

1.5 Application

These Rules and Regulations apply to all Professional Staff Members. Appointment to the Professional Staff is granted with the expectation that Professional Staff Members will abide by these Rules and Regulations.[6] Note, when an article/section of the Rules and Regulations is intended to specifically apply to only a segment of the Professional Staff, that has been expressly stated.

1.6 Maintenance

(a) **Posted on Website.** These Rules and Regulations, along with any amendments from time to time, shall be posted on the Hospital's website.

(b) **Periodic Review.** The Medical Advisory Committee may review these Rules and Regulations as it determines appropriate, provided that it shall undertake a comprehensive review at least every three years.

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4 See *Public Hospitals Act (Ontario) Regulation 965* section 7(2)(a)(vii).
5 See Professional Staff By-law section 9.2.
6 Pursuant to Professional Staff By-law section 3.2, Professional Staff are required to comply with these Rules and Regulations.

1.7 Amendment Process

(a) **Notice of Recommended Amendments.** The Medical Advisory Committee shall provide at least fourteen days' notice to the Professional Staff of any amendments to these Rules and Regulations that it is considering recommending to the Board. Notice may be given by email.

(b) **Finalizing Recommendations.** The Medical Advisory Committee shall finalize any recommendations regarding these Rules and Regulations at a duly constituted meeting of the Medical Advisory Committee, after the notice period set out in section 1.8(a) has passed and after considering (without obligation to follow) any input received from the Professional Staff.

(c) **When Effective.** Amendments to these Rules and Regulations become effective when recommendations of the Medical Advisory Committee are approved by the Board.

ARTICLE 2: DUTIES AND BREACH CONSEQUENCES

CONTENTS

2.1 Overview

Professional Staff members shall have and comply with the general duties set out in the Professional Staff By-laws[7] along with the specific duties associated with the category of Professional Staff to which the Professional Staff Member has been assigned,[8] in addition to any other duties as may be applicable.[9]

2.2 Confidentiality Emphasized

Among Professional Staff duties is the requirement to maintain confidentiality as per the Confidentiality Agreement Schedule.

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7 See article 3 of the Professional Staff By-laws, which detail duties that all Professional Staff Members have.

8 See article 4 of the Professional Staff By-laws, which lists the different categories of Professional Staff as well as specific duties relating to each.

9 Depending on the circumstances, a Professional Staff Member may have other duties such as, for examples, duties relating to their Privileges and duties arising under contract.

2.3 Breach Consequences

A failure to abide by applicable duties, including compliance with these Rules and Regulations, will constitute a breach of the Professional Staff Member's duties, which may result in any one or more of the following consequences as appropriate:[10]

(a) any application for re-appointment to the Professional Staff may be rejected, suspended, or any re-appointment may be made subject to such conditions and/or restrictions as the Board determines appropriate;

(b) Non-Immediate or Immediate Mid-Term Action, in accordance with articles 5 and 6 of the Professional Staff By-laws may be initiated, which may result in the suspension,[11] restriction[12] or revocation[13] of the Professional Staff Member's appointment and/or Privileges;

(c) consequences as otherwise detailed in the Professional Staff By-laws, these Rules and Regulations and/or Policies may apply;

(d) consequences as detailed in any contract between the Professional Staff Member and the Hospital may apply; and

(e) consequences as otherwise mandated or available at law may apply.

ARTICLE 3: ORIENTATION AND REFRESHER TRAINING

CONTENTS

3.1 Orientation

(a) **Purposes.** The purposes of orientation are to ensure new Professional Staff are oriented to Hospital facilities, systems, Policies, procedures and practices, so as to allow them to smoothly integrate into the Professional Staff and to appropriately support them in the provision of safe and effective patient care.

(b) **Timing.** All new Professional Staff shall undergo an orientation as soon as reasonably possible following their appointment, prior to any exercise of their Privileges.

(c) **What is Included.** Orientation shall include:

(i) A general orientation to the Hospital facilities.

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10 This provision tracks section 3.12 of the Professional Staff By-laws.

11 "Suspension" in this context means the temporary revocation of some or all of one's privileges. A suspension may be immediate or non-immediate.

12 "Restriction" in this context means any negative modification, reduction, reassignment, or change to a Professional Staff Member's privileges.

13 "Revocation" in this context means the withdrawal or cancellation of some or all of one's privileges after they have been granted.

(ii) A more detailed orientation to the Program to which the Professional Staff Member is appointed.

(iii) A review of the following in concert with such individual who has been assigned to assist with such review:

(1) By-Laws.
(2) Hospital vision, mission and philosophy and values.
(3) Rules and Regulations.
(4) Affiliation Agreement.
(5) Code of Conduct.
(6) Associate / Active Staff evaluation forms.
(7) Prevention of Workplace Violence Program.
(8) Patient/Visitor Safety Reporting System.
(9) The Hospital policies listed in the Policy Review Requirements Schedule.
(10) All Program specific policies.

(iv) Such other items as determined appropriate by the Program Medical Director for the Program towhich the new Professional Staff Member is appointed.

(d) **Responsibility.** The Program Medical Director for the Program to which the new Professional Staff Member is appointed, shall be responsible for ensuring the new Professional Staff Member is given orientation and as part of that, shall ensure the involvement of such individuals as are appropriate.

(e) **Documenting Orientation.** Orientation shall be documented, with such documentation to be placed in the new Professional Staff Member's credentialing file.

3.2 Refresher Training

Professional Staff Members shall maintain their familiarity with all items listed in section 3.1(c)(iii) above, as the same may be amended from time to time and annually in the context of their re-appointment to the Professional Staff.

ARTICLE 4: SUPERVISION OF ASSOCIATE STAFF

CONTENTS

4.1 Purposes

The purposes of supervision shall be to: assist Associate Staff to smoothly integrate into the Professional Staff; to enhance performance by providing advice and support as appropriate; and provide a monitoring function.[14]

4.2 Qualifications

Supervisors shall meet the following qualifications:

(a) Member of the Active Staff.[15]

4.3 Appointment

Upon appointment, each Associate Staff Member shall be assigned a Supervisor, who shall be appointed by either the Chief of Staff or the Program Medical Director of the Program to which the Associate Staff member is appointed.

4.4 Duties

Duties of supervisors shall include the following:

(a) **Guide and Monitor.** Supervisors shall:

- (i) Observe the Associate Staff Member's performance of procedures and practice in the Hospital.
- (ii) Review the Associate Staff Member's charts and work in order to evaluate the competence of the Associate.
- (iii) Guide and advise the Associate Staff Member on applicable systems, Policies, procedures and practices.
- (iv) Encourage the appropriate use of Hospital resources.
- (v) Complete performance reviews of the Associate Staff Member and provide reports as required by section 4.4(c) of these Rules and Regulations.

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14 For a discussion on the potential benefits of mentoring see, Taherian K and Shekarchian M., Mentoring for doctors. Do its benefits outweigh its disadvantages? (2008).

15 See section 4.3€(ii) of the Professional Staff By-laws, which provides that Associate Staff will be under the supervision of an appointed Active Staff member.

(b) **Alert if Concerned.** A supervisor shall immediately inform the Chief of Staff or Program Medical Director, of any concerns regarding the Associate Staff Member's competency or conduct.

(c) **Performance Reviews**. Associate Staff reviews shall be completed by the assigned supervisor and Program Medical Director on or before the expiry of the Associate Staff Member's sixth, twelfth, eighteenth, and twenty-fourth month probationary terms and a review report shall be submitted to the Credentials and Medical Advisory Committees at every interval. The Associate Staff review report shall be in the form of the Associate Staff Review Report Schedule.[16]

ARTICLE 5: MEETINGS

CONTENTS

5.1 Professional Staff Association Meetings

(a) **Entitlement to Attend.** All Professional Staff are entitled to attend all Professional Staff Association meetings.

(b) **Mandated Attendance.** Active and Associate Staff shall attend at least fifty percent[17] of the Professional Staff Association meetings in any calendar year. For greater clarity, unless otherwise required,[18] all other Professional Staff are not subject to this mandatory attendance requirement.[19]

5.2 Program Meetings

(a) **Entitlement to Attend.** All Professional Staff are entitled to attend all Program meetings.

(b) **Mandated Attendance.** Active, Associate, Temporary and Senior Professional Staff shall attend at least seventy percent of the meetings of the Program to

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16 This aligns with section 4.3(e)(iii) of the Professional Staff By-laws.
17 See Professional Staff By-laws sections 4.2(d)(v), 4.3(d)(v), 4.5(d)(v) and 4.9(d)(r).
18 For example, as per Professional Staff By-laws section 4.7(c)(ii), Consulting Staff may be required to attend Program meetings if specified by the Board.
19 See Professional Staff By-laws sections 4.4(d)(v), 4.6(d)(v), 4.7(d)(v), 4.8(d)(v), 4.10(d)(v), 4.11(d)(v) and 4.12(d)(v).

which they are appointed in any calendar year.[20] For greater clarity, unless otherwise required, all other Professional Staff are not subject to this mandatory attendance requirement.[21]

5.3 Patient Related Meetings

(a) **Notice.** When the case of a patient is to be presented at a Program meeting; MQA meeting pursuant to the *QCIPA*; or at a meeting of the Medical Advisory Committee, the Professional Staff Member who examined, treated or otherwise materially participated in the care of the patient, such Professional Staff Member shall be given at least forty-eight hours notice by the Chief of Staff and/or the relevant Program Medical Director.

(b) **Mandated Attendance.** A Professional Staff Member who has received notice as contemplated by section 5.3(a) above, shall attend such meeting, prepared to present and discuss the case at the meeting.

5.4 Credentials Committee Meetings

(a) **Notice.** A Professional Staff Member who is required to attend a Credentials Committee meeting shall be given at least forty-eight hours notice by the chair of the Credentials Committee.

(b) **Mandated Attendance.** A Professional Staff Member who has received notice as contemplated by section 5.4(a) above, shall attend such meeting.

5.5 Breach of Meeting Attendance Requirements

If any member of the Professional Staff, without written reasons acceptable to the Medical Advisory Committee, fails to meet any of the mandated attendance requirements above, the Medical Advisory Committee shall recommend to the Board that the delinquent member:

(a) be removed from the Professional Staff;
(b) be suspended from the Professional Staff for a specified period of time; or
(c) work within certain restrictions upon their Privileges for a specified period of time.

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[20] See Professional Staff By-laws sections 4.2(c)(iii), 4.3(c)(iii), 4.5(c)(ii) and 4.9(c)(ii).
[21] See By-law ss. 17.04(b); 17.06(d); 17.07(b); and 17.10(d).

ARTICLE 6: PROFESSONAL DEVELOPMENT

CONTENTS

6.1 Core Competencies

Each Program may make recommendations to the Medical Advisory Committee on a list of "core" competencies (including certifications), which every Professional Staff Member must maintain as a condition of appointment and/or re-appointment.

6.2 Supplemental Clinical Procedures

Each Program may make recommendations to the Medical Advisory Committee on additional procedures which Professional Staff Members may apply for upon provision of evidence of appropriate training.

6.3 CPD/CME[22]

(a) **Requirement to Complete.** All Professional Staff Members shall complete CPD/CME that is related to their area of practice at the Hospital.

(b) **Proof of CPD/CME.** All Professional Staff must submit documentary proof that they are meeting the standard for CPD/CME recognized by their College, along with their annual application for re-appointment to the Professional Staff.

(c) **Proof for Previous Year.** The documentary proof submitted by all Professional Staff must pertain to CPD/CME completed during the calendar year prior to the application for re-appointment being submitted (CPD/CME undertaken between January 1 – December 31).

(d) **College CPD/CME Report Required.** The documentary proof submitted by all Professional Staff must include, at a minimum, a report in the form submitted to their College.

(e) **Provide Additional Proof.** Professional Staff Members must comply with all requests by their Program Medical Director for additional information or documentary proof of CPD/CME, including for example, a request for

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[22] Professional Staff By-law section 7.3(e) requires the Program Medical Director, as part of the annual re-application process to report on the Professional Staff Member's performance, including whether the Professional Staff Member has met the standard for CPD/CME by the applicable College.

certificates of completion, in order for their applications for re-appointment to be considered complete.

(f) **Process if Concerns.** The Chief of Staff and/or Program Medical Director may refer concerns regarding a Professional Staff Member's CPD/CME to the Credentials Committee for review and recommendation. The Credentials Committee may in turn, refer concerns regarding a Professional Staff Member's CPD/CME to the Medical Advisory Committee for review and recommendation.

ARTICLE 7: REPORTING OF CHANGES TO STATUS

CONTENTS

7.1 Obligation to Report

Pursuant to the Professional Staff By-Law,[23] Professional Staff have an on-going obligation to forthwith advise the Chair of the Credentials Committee, the Vice-President of Medical Affairs or Chief of Staff and their Program Medical Director of any changes during the credentialing year to the information provided in their application for appointment or re-appointment, as the case may be, including any changes to their status in connection with their College; other hospitals/health care facilities; their health; and/or legal matters (criminal and civil).

7.2 Initial Reporting Process

All required change in status reports as contemplated by section 7.1 above shall be in writing.

7.3 Obligations Following Initial Report

(a) **Certificate of Professional Conduct.** Changes to status with the Professional Staff Member's College may require an updated Certificate of Professional Conduct or equivalent. The requirement will be at the discretion of the Chief of Staff in consultation with the relevant Program Medical Director. Professional Staff Members shall complete any related consents and releases and are responsible for any fees for obtaining this documentation.

(b) **Criminal Records Check.** Changes to status with respect to criminal matters may require an updated criminal records check. The requirement will be at the

[23] See Professional Staff By-law section 3.3(a). for a complete list of the information required to be updated.

discretion of the Chief of Staff in consultation with the relevant Program Medical Director. Professional Staff Members shall complete any related consents and releases and are responsible for any fees for obtaining this documentation.

(c) **Additional Information.** Professional Staff Members must immediately comply with all written requests by the Chief of Staff or the chair of the Credentials Committee for additional information regarding their initial report as contemplated by section 7.2 above. All such additional information shall be given in writing.

7.4 Report Processing Requirements

(a) **Forwarding of Change of Status Report.** All change of status reports received shall be forwarded to the President and CEO by the Vice-President, Medical Affairs or Chief of Staff, depending on who has received it, and to the Vice-President, Medical Affairs if received by the Chief of Staff and vice-versa.

(b) **Coordination of Follow-Up.** Follow-up inquiries, if any, will be coordinated by the Chief of Staff, either through his/her office or through the Credentials Committee.

(c) **Coordination of Monitoring.** Monitoring of pending or on-going matters related to all Change in Status Reports will be coordinated by the Chief of Staff, either through his/her office or through the Credentials Committee.

ARTICLE 8: LEAVES OF ABSENCE

CONTENTS

8.1 Leaves of Absence

Leaves of absences shall be subject to and in accordance with the following:

(a) **Board Decision.** The Board may grant a leave of absence, not exceeding twelve months, on the recommendation of the Medical Advisory Committee.

(b) **When Rescindable.** A leave of absence may be rescinded if:

(i) The Hospital's Professional Staff resource plan identifies the specialty of the Professional Staff Member on leave of absence as one where the needs of the Professional Staff Member's Program are not being met while the Professional Staff Member is on leave; and

(ii) a new qualified candidate applies for the position.

(c) **Notification of Decision.** The Professional Staff Member will then be notified that their leave of absence is rescinded and afforded the opportunity to return immediately. Only if the Professional Staff Member on leave declines the offer, can the new candidate be appointed as a replacement to the Professional Staff.

(d) **Time for Re-application.** A Professional Staff Member who is on leave of absence must apply for re-appointment to the Professional Staff at least three months before his/her return from leave or if the leave is less than three months, at least two weeks before.

(e) **Medical Advisory Committee Recommendation.** The Medical Advisory Committee may then make a recommendation to revoke, suspend or alter the Professional Staff Member's appointment and/or Privileges. The Medical Advisory Committee shall provide notice to the Professional Staff Member and the Board of its recommendation in accordance with the provisions of the *Public Hospitals Act (Ontario)* and By-Laws.[24]

8.2 Extended Leaves of Absence

In situations where, due to unforeseen circumstances, leaves of absence exceed the period of time granted by the Board and/or exceed the maximum period of twelve consecutive months, the Professional Staff Member's clinical judgment, skills and competency will be assessed and appropriate orientation, assessment, mentoring, monitoring and supervision will be implemented and documented and the "Professional Staff Return from Leave of Absence Policy and Form" set out in the related Schedule shall apply.

ARTICLE 9: PATIENT ADMISSIONS AND DISCHARGES

CONTENTS

9.1 Admissions - General

(a) **By Authorized Professional Staff.** Subject to the *Public Hospitals Act (Ontario) Regulation 965,*[25] the By-laws, these Rules and Regulations and the terms of the Professional Staff Member's appointment and Privileges, Professional Staff Members may admit patients to Hospital.

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[24] See Professional Staff By-law sections 2.5(e) and 2.2(a)(v)(G).

[25] Note, the *Public Hospitals Act (Ontario) Regulation 965* requires that if the person is being admitted for treatment by a dentist who is a member of the dental staff **other than** an oral and maxillofacial surgeon, the admission must be on the joint order of the dentist and a physician who is a member of the medical staff.

(b) **Must Be Clinically Necessary.** As required by the *Public Hospitals Act (Ontario) Regulation 965,*[26] no patient may be admitted to Hospital unless, in the opinion of the Professional Staff Member, such admission is clinically necessary.

(c) **Provisional Diagnosis Required.** The Professional Staff Member must provide a provisional diagnosis and rationale at the time of admission.

(d) **Documenting Admission.** Upon admission, the admitting Professional Staff Member shall be responsible for documenting patient: medical/dental history; the results of the physical examination; and the provisional diagnosis.[27]

9.2 Discharges - General

(a) **Planning Upon Admission.** The discharge planning process shall begin at the time of patient admission. Professional Staff Members will be expected to participate in the discharge planning meeting to assist with identifying barriers.

(b) **MRP Responsible.** Discharges are the responsibility of the MRP based on clinical judgment and discussion with appropriate Hospital staff.

(c) **Treat as Out-Patient When Possible.** Whenever possible, further tests, procedures or appointments shall be arranged as an out-patient, with appropriate follow-up arranged.

(d) **Timing.** Timing of discharges shall be subject to and in accordance with the following:

(i) **All Days of the Week.** Discharge can take place every day of the week, provided adequate support services can be accessed by the patient.

(ii) **Confirmed by 0900 Hours.** Discharges shall be confirmed by 0900 hours on the day of discharge, so that the discharge process can be completed. If the MRP is not seeing the patient before this time, a prescription for any required medication will be made out on the previous day.

(iii) **Bed Vacated by 1100 Hours.** Effective discharge planning means that patients who are being discharged should vacate their beds before 1100 hours on the day of discharge.

(iv) **No Weekend Delay.** Patients who are ready for discharge on the weekend should not be delayed until the MRP returns after the weekend.

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[26] See *Public Hospitals Act (Ontario) Regulation 965* section 11(2).

[27] Also see Rules and Regulations article 10 regarding additional documentation requirements for Professional Staff Members with respect to admissions, re-admissions and repeat visits.

(e) **Requirements Prior to Discharge.** Prior to patient discharge, the following requirements shall be met:

(i) **Ensure Outcomes Ready.** Required outcomes, i.e. lab work, should be ordered the day before so that results can be available on the unit when the MRP or Covering Professional Staff Member undertakes rounds.

(ii) **Provide Discharge Instructions.** The MRP or Covering Professional Staff Member must ensure that the patient is provided with discharge instructions, including review of medication, any required treatments, diet, activity, home support if required, and follow-up appointments.

(f) **Responsibility for Follow-up.** The MRP or Covering Professional Staff Member is responsible for ensuring appropriate follow-up on test results for tests ordered during a patient's stay at the Hospital, in circumstances where these results are not available on discharge. This responsibility includes test results for tests ordered by way of a telephone consultation.[28]

(g) **Communication with Patient.** Ongoing communication should occur with each patient and/or substitute decision maker about estimated date of discharge, daily patient goals and reinforcement of expectation about vacating the bed before 1100 hours.

9.3 Discharge Against Advice

(a) **Warning to Patient.** When a patient insists upon leaving the Hospital against the advice of the MRP/Covering Professional Staff Member, he or she shall be warned of the consequences of doing so.

(b) **Document and Seek Release.** If the Professional Staff Member is present, a statement describing the circumstances shall be entered by the Professional Staff Member in the patient's health record and the patient shall be asked to sign a release form. The Professional Staff Member shall detail, in writing, the specific risks outlined to the patient, in an effort to ensure the patient makes an informed decision.

(c) **Still Follow-up Tests.** The MRP or Covering Professional Staff Member is responsible for ensuring appropriate follow-up on test results ordered during a patient's admission despite the patient leaving the Hospital against the advice of the MRP or Covering Professional Staff Member.[29]

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[28] See the College of Physicians and Surgeons of Ontario's, Test Results Management, Policy #1-11 regarding the steps physicians are expected take to help prevent failures in follow-up on test results.

[29] See the College of Physicians and Surgeons of Ontario's, Test Results Management, Policy #1-11 regarding the steps physicians are expected take to help prevent failures in follow-up on test results.

9.4 Discharge Hours

Patients shall be discharged by 1100 hours, only on the order of the MRP or the Covering Professional Staff Member, or the Professional Staff Member to whom the MRP or the Covering Professional Staff Member has delegated the duty.

ARTICLE 10: CONTINUITY OF MEDICAL COVERAGE

CONTENTS

10.1 MRP

(a) **One MRP Per Patient.** There shall be an MRP identified for each patient.

(b) **Duties.** The MRP or the Covering Professional Staff Member shall:

(i) **Assessment Within Twenty-Four Hours.** The MRP (or delegate as clinically appropriate, i.e. nurse practitioner, resident, physician assistant) shall assess the clinical condition of the patient within twenty-four hours of the patient's admission to the Hospital.

(ii) **Visit Frequency.** Subject to the exception in section 10.1(b)(3), make an appropriate number of visits based on the current minimum program standards (note, the Medical Advisory Committee will establish program minimum standards and will revise these standards in consultation with the Program Medical Director and Clinical Lead when appropriate):

(1) Restorative Care Program:
1. Complex Medical Care – twice weekly.
2. Palliative Care Unit – three times weekly.
3. Rehabilitative Program – daily.
4. Physiatrists – once weekly.

(2) Brain and Behaviour Program – Psychiatrists, three times weekly at minimum; Hospitalists - twice weekly at minimum.

(3) The exception to section 10.1(b)(ii) above is when the following applies:
1. when there is a change in patient status;
2. when there is an urgent need to visit the patient;
3. when directed by the MRP or per the request of nursing staff; and/or
4. standards for urgent weekend visits.

(iii) **Telephone Response Within Thirty Minutes.** Respond by telephone within thirty minutes for continuing medical/dental problems.

(iv) **Direct Response to Urgent Problems.** Respond to new urgent problems by attending at the unit to directly assess the patient.

(v) **Communicate with Circle of Care.** Maintain either verbal or written active communication with the other members of the health care team involved in the care of the patient.

(vi) **Communicate with Family.** Communicate with the patient's family, as appropriate.

(vii) **Document in Health record.** Enter appropriate progress notes in the health record. An appropriate progress note will accurately reflect the changing clinical condition of the patient.

(viii) **Follow-up on Testing.** Ensure appropriate follow-up on results for tests ordered during a patient's stay, including where the results are not available on discharge.[30]

10.2 Consultations

(a) **When to Seek.** In the following circumstances, the MRP or Covering Professional Staff Member shall seek a Consultation with one or more appropriate members of the Active or Consulting Staff:
(i) on patients where there is a failure to progress as expected under treatment; and
(ii) on patients where a serious problem of diagnosis or management exists.

(b) **Referring Professional Staff Member Duties.** Duties of the referring Professional Staff Member shall include the following:

(i) **Inform Patient.** When possible, the Professional Staff Member or designate shall inform the patient and/or substitute decision maker of the need for a Consultation.

(ii) **Consultation Request.** The referring Professional Staff Member shall complete a legible consultation request, which includes, at a minimum:
(1) the relevant medical history of the patient;
(2) the reason for the Consultation and the specific question(s) to be answered by the Consultant; and
(3) the urgency of the Consultation, i.e. urgent or non urgent.

(c) **Consultant Duties.** Duties of Consultants shall include the following:

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[30] See the College of Physicians and Surgeons of Ontario's, Test Results Management, Policy #1-11 regarding the steps physicians are expected take to help prevent failures in follow-up on test results.

(i) **Honour Requests.** Honour and/or address any and all Consultation requests.

(ii) **Time Frame for Completion.** Complete all non urgent consults in a time frame agreed between the Consultant and MRP.

(iii) **Response Time.** Respond within a time frame appropriate to the situation.

(iv) **Contemporaneous Documenting in Health Record.** Record the pertinent findings and recommendations in the health record at the time of Consultation. For greater clarity, the detailed report can follow.

(v) **Report.** Consultation reports shall contain a written opinion by the Consultant, based on an examination of the patient and a review of the patient's health record.

10.3 Patient Transfers Between MRPs[31]

Patient transfers between MRPs shall be subject to and in accordance with the following:

(a) **Clarity as to MRP Required.** At all times, it shall be clear on the patient's record who is the MRP.

(b) **Direct Communication Between MRPs.** The transferring MRP shall communicate directly with the accepting MRP prior to transfer.

10.4 Patient Transfers Away from the Hospital

Patient transfers to another hospital or health care facility shall be in accordance with and subject to the following:

(a) **From and To a Professional Staff Member.** Patients shall be transferred from the care of a Professional Staff Member at the Hospital to the care of a professional staff member at the accepting hospital/health care facility.

(b) **Direct Communication Between Professional Staff Members.** The transferring Professional Staff Member shall communicate directly with the accepting Professional Staff Member prior to transfer.

10.5 Patient Transfers to the Hospital

[31] Note that section 10.3 of these Rules and Regulations does not apply to weekend coverage arrangements.

(a) **From and to a Professional Staff Member.** Patients shall be transferred from the care of a professional staff member at the transferring hospital/health care facility to the care of a Professional Staff Member at the Hospital.

(b) **Ensure Capacity Prior to Acceptance of Transfer.** The accepting Professional Staff Member shall discuss the Hospital's ability to admit the patient to be transferred with appropriate staff members at the Hospital (to confirm availability of resources, staffing, beds, etc.) prior to accepting the patient from the professional staff member at the transferring hospital/health care facility.

10.6 Delegated Controlled Acts Require Medical Advisory Committee Approval

All delegation of any "controlled acts" within the meaning of the *Regulated Health Professions Act, 1991* to be performed in the Hospital must be approved by the Medical Advisory Committee.

ARTICLE 11: DOCUMENTATION

CONTENTS

11.1 Health Records – Communication Tool

Health records shall be completed and reviewed recognizing that the health record is a record of the patient's stay in the Hospital and is an important means of communication among health care professionals.

11.2 Content of Health Records

Contents of health records shall be subject to and in accordance with the following:

(a) **Compliance with *Public Hospitals Act (Ontario) Regulation 965*.** The health record shall contain sufficient information to indicate what progress was made by the patient, what problems developed with the patient, the assessment of the problems and the care that was rendered and shall otherwise comply with the *Public Hospitals Act (Ontario) Regulation 965*.[32]

(b) **Only Approved Abbreviations.** Professional Staff Members shall only use abbreviations that have been approved for use on the facility-wide abbreviation list.

(c) **Legible Entries.** Written entries in health records shall be written in a legible manner.

11.3 Responsibility for Completion of Health Records

Each Professional Staff Member shall be responsible for documenting in the patient's health record, the care that he or she has rendered to the patient.

11.4 Authentication of Health Records

Authentication of health records shall be subject to and in accordance with the following:

(a) **Authentication Required.** All entries in the patient's health record shall be authenticated.

(b) **Handwritten Entries.** All handwritten entries shall be authenticated by personal signature.

(c) **Dictated Entries.** All dictated entries shall be authenticated in accordance with the following process:

(i) **Authentication Process.** Complete dictations shall be deemed to be authenticated unless further revised by the Professional Staff Member as follows:

(1) the Health Information Management Department will send a hard copy of the complete dictation to the Professional Staff Member's office;
(2) the Professional Staff Member shall review the dictation;
(3) revisions may be made on the electronic copy of the dictation;

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[32] See *Public Hospitals Act (Ontario) Regulation 965* section 19 for requirements relating to health record content.

(4) revisions shall be faxed to the Health Information Management Department for amendment;
(5) the Health Information Management Department will amend the dictation, which will override the previous report in Solcom. The revised dictation will be deemed to be the authenticated version; and
(6) the Professional Staff Member will be sent a revised electronic copy of the dictation.

(ii) **Incomplete Dictations.** Incomplete dictations or dictations requiring clarification will be sent to the Solcom workbasket of the Professional Staff Member for their electronic correction and completion, then sent back to the Health Information Management Department electronically. The Health Information Management Department will then revise the dictation, which will be deemed to be authenticated unless further revised by the Professional Staff Member as set out above pursuant to section 11.4(c)(i).[33]
(1) The statement "Dictated But Not Read" in the original dictation will not satisfy the requirement to complete and clarify the dictation.

11.5 Correction of Health Records

Correction of health records shall be subject to and in accordance with the following:

(a) **Only To Ensure Accuracy.** Modification of health records shall only be made when it is necessary to ensure accuracy.

(b) **Manner of Correction.** Corrections must be made in such a manner as to ensure that the correct information is recorded, with the additions or changes dated and initialled.

(c) **Retention of Incorrect Information.** Incorrect information may be either severed from the health record and stored separately in the Hospital, or maintained in the health record but clearly labelled as being incorrect. Where incorrect information is maintained in the health record, the Professional Staff Member must ensure that the information remains legible.

(d) **Severed Information Must Be Traceable.** Where the incorrect information is severed from the health record, the Professional Staff Member must ensure that there is a notation in the health record that allows for the incorrect information to be traced.

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[33] The time lines for completion of charts/incomplete health records are set out under section 9.18 of these Rules and Regulations regarding "Chart Completion/Incomplete Health Records" and are applicable to "Incomplete" dictations/dictations requiring clarifications.

11.6 Late Entries to Health Records

When a pertinent entry is missed or not written in a timely manner, the Professional Staff Member may make the late entry in the progress notes section of the health record or by way of an addendum, and must:

(a) record the late entry/addendum as soon as possible;
(b) identify the new entry as a "late entry" or an "addendum";
(c) record the current date and time on which the entry/addendum is being made – do not attempt to give the appearance that the entry was made on a previous date or an earlier time;
(d) identify or refer to the date and circumstance for which the late entry or addendum is written; and
(e) sign the entry/addendum.

11.7 Admission History and Physical Requirements

(a) **Content.** The template for admission history and physical requirements should incorporate the chief complaint(s), history of present illness, all pertinent lab and x-ray results, inventory of systems, past medical and surgery history, pertinent personal history, family and social history (including DNR status), medications and allergies, assessment and plan, plan of care, investigations, and a physical examination of all body parts and systems of the body, and *may include* a detailed physical examination of one or more parts or systems.

(b) **Requirements Within Twenty-Four Hours.** As per the MQA requirements, a written or dictated history and physical assessment and treatment plan must be completed within twenty-four hours of patient admission. The treatment plan shall contain working diagnosis, required investigations, therapy and disposition of patient when they recover.

11.8 Consent Documentation[34]

Documenting patient consent shall be subject to and in accordance with the following:

(a) **Responsibility.** The obtaining of written verification of patient consent for diagnostic procedure and/or medical/dental treatment, is the responsibility of the Professional Staff Member performing the diagnostic procedure, or medical/dental treatment. For electroconvulsive therapy (ECT) patient consent must be obtained by both the MRP ordering ECT and by the psychiatrist performing ECT.

(b) **Validity Period.** The period of time for which consent shall be valid shall be subject to and in accordance with the following:

[34] Also see s. 11.4 of these Rules and Regulations regarding refusal to consent situations.

(i) **In-Patients.** Patient consent is valid from the time that it is obtained until the time of the patient's discharge, unless consent has been revoked by the patient or their substitute decision maker.

(ii) **Out-Patients.** Consent for an out-patient is valid for the plan/course of treatment, but must be reviewed on a yearly basis.

11.9 Advanced Directives

Completion of advanced directives as per the Advanced Healthcare Directives and Power of Attorney for Personal Care Schedule is mandatory for all services pertaining to all admitted in patients.

11.10 Progress Notes

Progress notes shall be subject to and in accordance with the following:

(a) **Entered into Health Record.** A Professional Staff Member's progress notes, including updates about the plan of care, must be entered into the patient's health record.

(b) **Sequential.** Progress notes, including late entries, should be sequential, based on the date when the entry is being recorded.

(c) **Frequency.** All progress notes must clearly outline patient status and shall be written at each visit, based on the current visit frequency as outlined in section 10.1(b)(ii). In all cases of an unexpected change in a patient's condition, a note shall be written. Professional Staff Members shall ensure the content of their progress notes meet the current requirements established by the CPSO (Policy Number #4-12 Medical records).

11.11 Orders - Treatment or Diagnostic Procedure

Orders for treatment or diagnostic procedures shall be subject to and in accordance with the following:

(a) **Documented in Health record.** All orders for treatment, or for a diagnostic procedure, on a patient must be in writing, dated, and authenticated by a Professional Staff Member in the patient's health record, in the section designated for Professional Staff Members' orders. The Professional Staff Member shall print their name directly below their signature.

(b) **Verbal Orders.** Verbal orders may only be accepted by the nursing staff in urgent situations and should be authenticated by the Professional Staff Member who made the order, within seven days.

(c) **Telephone Orders.** Telephone orders shall be accepted and recorded only by qualified personnel, i.e. registered nurses, pharmacists, respiratory therapists, clinical dieticians, and shall be authenticated by the responsible Professional

Staff Member's signature as soon as possible on his/her first visit to the Hospital thereafter.

(d) **Legible.** Orders shall be legible.

(e) **Medical Students.** Entries into a patient's health record by a medical student shall be subject to and in accordance with the following:

(i) **Undergraduate Medical Students.** Any orders, histories, progress notes or other documents written by an undergraduate medical student in a patient's health record must be countersigned by the MRP.

(ii) **Postgraduate Medical Students (Residents).** Orders, histories, progress notes or other documents written by a postgraduate medical student (resident) will not require countersignature.

(iii) **Always Signed by Student.** All medical students (undergraduates and postgraduate) shall print their name and designation directly below their signatures.

(f) **Email/Text Orders.** Orders received by email or through telephone text are not acceptable.

11.12 Orders – Medication

Orders for medication shall be subject to and in accordance with the following:

(a) **Legible.** All medication orders must be written legibly.

(b) **Metric System.** Medication dosages shall be ordered using the metric system exclusively.

(c) **Content.** Medication orders shall include medication name, strength, desired route of administration and directions.

(d) **Only Medical Advisory Committee Approved Abbreviations.** Only Medical Advisory Committee approved abbreviations related to medications, as listed in the Drug Formulary, shall be used.

(e) **STAT Orders.** Orders which need to be started in less than two hours are considered STAT orders. A Professional Staff Member may call the Hospital pharmacy to issue a verbal order for a STAT medication.

(f) **Administration of Medication.** Unless specifically indicated on the medication order, all medication shall be administered according to approved Standard Administration Times, as listed in the Drug Formulary.

(g) **Automatic Stop Orders.** Automatic Stop Orders are important to ensure review of patient medication regimens, to help avoid potential toxicity or

dependence resulting from prolonged use of specific medications, and to help avoid emergence of resistant organisms to antibiotics.

11.13 Coding Requirement Related Forms

Any forms designed to capture specific coding requirements shall be completed by all applicable services. Such forms must be filled in and updated throughout the patient stay as outlined by the Hospital.

11.14 Discharge Documentation

Discharge documentation shall be subject to and in accordance with the following:

(a) **Summary Within Seven Days.** A dictated discharge/death summary must be completed for all admitted patients within seven days of discharge. The summary must include, as relevant:
- (i) the one diagnosis most responsible for the Hospital stay;
- (ii) pre-admission co-morbidities and complications affecting Hospital stay;
- (iii) post-admission co-morbidities and complications affecting Hospital stay;
- (iv) a brief and concise narrative of course in the Hospital, including:
  - (1) identifying significant diagnoses/problems that impact the complexity of the case and/or estimated length of stay (ELOS);
  - (2) using terms such as “acute”, “severe”, “exacerbation” where appropriate;
  - (3) using terms such as “due to”, “related to” or “secondary to” as appropriate, in order to link the cause and effect diagnoses; and
  - (4) avoiding use of equivocal terms such as, “possible”, “probably”, “likely” and “might be”.
- (v) discharge plan; and
- (vi) medication list.

(b) **Balance Within Seven Days.** In all cases, the balance of the documentation should be completed within seven days of discharge.

(c) **Responsibility.** The Professional Staff Member who writes the discharge order shall be responsible for the completion of the discharge documentation.

11.15 Death Certificates

When a patient dies in Hospital, the MRP shall cause a copy of the medical certificate of death to be filed in the health record pertaining to the patient within twenty-four hours after the death of the patient.

11.16 Completion of Health Records

Completion of health records shall be subject to and in accordance with the following:

(a) **Chart Completion.** The Hospital's Chart Completion Policy (see Policy Review Requirements Schedule for link).

(b) **Notify Hospital of Absence.** It is the responsibility of the Professional Staff Members to notify the Health Information Management Department when they are not available due to vacation or illness. Prior to any planned leave, Professional Staff Members must complete all outstanding patient health records.

11.17 Re-Admission

All re-admissions will require a full admission assessment by the MRP.

11.18 Repeat Visits

When a patient returns to the Hospital from time to time for repeat visits for any treatment including a series of visits for the same injury or illness, a note by the MRP indicating the reason for the return visit, the patient's current clinical status and a diagnosis shall be recorded in the patient's health record.

11.19 Patient Billing Documentation

Members of the Professional Staff shall ensure they ethically follow all OHIP billing requirements. Note, per the MOHLTC "*Physician Services under the Health Insurance Act,*" a patient assessment is defined as "A direct physical encounter with the patient including taking a patient history and performing a physical examination."

11.20 No Removal of Health Records

All health records are the property of the Hospital. Professional Staff Members shall not remove health records from the Hospital.

11.21 Patient Access to Health Records

When a patient or a substitute decision maker makes a request to receive a copy of or see a health record, the attending Professional Staff Member will be informed. The Professional Staff Member will discuss the contents of the health record with the patient at the patient's request. In all cases, the patient will be provided with copies of the whole or part of the health record requested subject to:

(i) Payment of any fee in accordance with the Hospital's fee schedule; and
(ii) The exemptions under the *Personal Health Information Protection Act, 2004* and the *Mental Health Act*.

11.22 Compliance with Health Information Management Department

Professional Staff Members must be familiar with and comply with the Health Information Management Department policy and procedure with respect to health records.

ARTICLE 12: OTHER CLINICAL MATTERS

CONTENTS

12.1 After-Hours EKGs

If a Professional Staff Member requests an after-hours EKG, the EKG should be done after-hours regardless of whether the Professional Staff Member is in the Hospital or not. The EKG should be done based on the clinical judgement of the requesting Professional Staff Member. The requesting Professional Staff Member is responsible for ordering the study responsibly, and for determining the urgency for reading/interpretation of the EKG. The requesting Professional Staff Member is also responsible for specifying if the reading/interpretation of the EKG is to be done on an "urgent" or "non urgent" basis and how the reading/interpretation will occur (on site, remotely and/or by an outside qualified regulated health professional) at the time when the request is being made. This information is to be documented at the time the request is being made.

12.2 Refusal of Consent[35]

Refusal of consent and patient capacity questioned shall be subject to and in accordance with the Hospital's Consent for Treatment/Services Policy (see related Schedule).

12.3 Autopsies

(a) **Identify When to Undertake.** Professional Staff Members shall identify cases where autopsies may be helpful to identify contributing factors and processes involved in the patient's death, and to provide sufficient clinical information for medical/dental care evaluation, education and research.

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[35] Also see s. 10.8 of these Rules and Regulations regarding obtaining consent, the relevant time lines for obtaining consent and the duration of the validity of the consent obtained.

(b) **Mandatory Reporting Duty.** Professional Staff Members shall be familiar with their mandatory duty to report in any of the circumstances specified in the *Coroners Act* which will require the coroner to take possession of and examine the body.

12.4 Organ and Tissue Donation

Professional Staff Members shall provide comprehensive end of life care, which shall ensure that every patient who is medically eligible to donate organs and/or tissues is given the opportunity to do so, in keeping with the *Trillium Gift of Life Network Act* and the Hospital's, "Combined Organ and Tissue Donation Procedure".

12.5 Dangerous and/or Infectious Patients

(a) A Professional Staff Member who knows or suspects that a person being admitted to the Hospital on the Professional Staff Member's order is or may become dangerous to himself or herself or to another person, shall forthwith notify the President, the CEO, plus the Program Medical Director and/or the Chief of Staff about the patient using the Code White – Persons Demonstrating Aggressive Behaviour (see related schedule).[36]

(b) An attending Professional Staff Member who knows or suspects that his or her patient is suffering from a serious infectious disease or condition shall forthwith notify the Admitting Department, the infection control officer/nurse, the President and CEO about the patient.[37]

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[36] See *Public Hospitals Act (Ontario) Regulation 965* section 14(1).
[37] See *Public Hospitals Act (Ontario) Regulation 965* section 14(2).

ARTICLE 13: SUB-COMMITTEES OF THE MEDICAL ADVISORY COMMITTEE

CONTENTS

13.1 Sub-committees of the Medical Advisory Committee

In accordance with Professional Staff By-Law section 9.8, the composition and terms of reference for the following standing sub-committees of the Medical Advisory Committee are included in these Rules and Regulations:

(a) Credentials Sub-committee.
(b) Executive Sub-committee.
(c) MQA Sub-committee.
(d) Regional Sub-committee.
(e) Infection Prevention and Control Committee.

13.2 General to all the Medical Advisory Committee Sub-committees

(a) **Composition.** Unless otherwise stated, all Medical Advisory Committee sub-committees shall:
  (i) have members selected on an annual basis by the Medical Advisory Committee from amongst the Professional Staff, as specified for each sub-committee;
  (ii) have a chair, who shall be a member of the Professional Staff, selected by the Chief of Staff in collaboration with the Vice-President, Medical Affairs;

(b) **Duties.** Unless otherwise stated, all Medical Advisory Committee sub-committees shall:

(i) meet as often as necessary to fulfill their duties and to meet the requirements of the *Public Hospitals Act (Ontario)*, the By-Law, the Rules and Regulations, and other relevant Legislation, and as requested by the Chief of Staff;
(ii) keep minutes of all meetings with records of attendance, copies of which shall be forwarded to the Medical Advisory Committee Executive Sub-committee; and
(iii) report to the Medical Advisory Committee at least annually or more often as necessary or as requested by the Chief of Staff.

(c) ***Ex Officio* Members.** The Chief of Staff and Vice-President, Medical Affairs and the CEO shall be members *ex officio* of all sub-committees of the Medical Advisory Committee. The *ex officio* members of the Medical Advisory Committee shall only count towards quorum, if he/she is present.

13.3 Voting

All members of the Medical Advisory Committee sub-committees shall have voting privileges, unless otherwise stated in these Rules and Regulations.[38]

13.4 Quorum

Except where otherwise stated in these Rules and Regulations, a quorum shall be forty percent of all members of the Medical Advisory Committee /sub-committee.[39]

13.5 Chair Responsibilities

The responsibilities of Medical Advisory Committee sub-committee chairs shall include the following:
(a) shall call meetings of the Medical Advisory Committee sub-committee;
(b) shall chair the Medical Advisory Committee sub-committee meetings;
(c) at the request of the Medical Advisory Committee, shall be present to discuss all or part of any report of the sub-committee; and
(d) may request meetings with the Medical Advisory Committee.

13.6 City Wide Joint Credentials Committee Terms of Reference (Sub-Committee of the Medical Advisory Committee)

(a) **Membership.** The Committee will include:
(i) the HDGH Chief of Staff, who shall nominate the other HDGH Committee members;
(ii) the WRH Chief of Staff, who shall nominate the other WRH Committee members;

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[38] This tracks By-law s. 21.09.
[39] This tracks By-law s. 21.10. Note, the MQA Committee has a majority quorum as per s. 12.7(h) and IPACC also has a majority quorum as per s. 12.9(e).

(iii) four (4) Active Staff members of WRH Medical Staff, at least two of whom must be Department Chiefs;

(iv) two (2) Active Staff members of the HDGH Medical Staff, one of whom must be a psychiatrist, if the HDGH's Chief of Staff is not a psychiatrist and both of whom must be Department Chiefs.

To ensure the Committee has the required expertise to perform its role, duties and responsibilities, the Chiefs of Staff shall ensure that, collectively, the Committee members reflect the diversity and depth of the various departments and clinical services provided by HDGH and WRH.

(b) **Chair.**

(i) The Committee will be co-chaired by the Chiefs of Staff or Department Chiefs respective designated by the Chiefs.

(ii) The co-chairs shall submit written reports to their respective PAC/MACs in respect of all of the Committee's recommendation.

(c) **Duties and Responsibilities.** To fulfill the duties of the City Wide Joint Credentials Committee, the Committee shall perform the following duties and responsibilities. The Committee will ensure that:

(i) Each applicant for appointment to the Professional Staff meets the criteria for appointment set out in the appropriate By-Laws.

(ii) Each applicant for re-appointment to the Professional Staff meets the criteria for reappointment set out in the appropriate By-Laws.

(iii) Each applicant for re-appointment or a change in privileges continues to meet the criteria for reappointment set out in the appropriate By-Laws.

(iv) It maintains a record of the qualifications and professional career of every member of the Professional Staff.

(v) Will consider reports of the interviews with the applicant.

(vi) Consult with the appropriate Chief of Department and receive and review the annual performance evaluation for the applicant in connection with an application for reappointment.

(vii) Ensure that notice of any interim evaluations of Associate Staff (as defined in the By-Laws) is sent to the appropriate Chief of Department.

(viii) Receive notification from the appropriate Chief of Staff when the performance evaluations and the recommendations for re-appointments have been completed.

(ix) Submit a written report to the appropriate PAC at or before its next meeting setting out its recommendations with respect to any application for appointment, re-appointment or change in privileges. The report will include the nature and extent of privileges requested by the applicant and, if necessary, a request that the application be deferred for further investigation in accordance with relevant section of the appropriate By-Laws.

(x) Monitor the status of any information provided during the appointment and reappointment process and any updates provided during the credentialing year regarding any pending or on-going College (as defined in the By-laws) investigations, assessments or proceedings, including any dispositions (other than no further action or dismissal), whether under appeal or review, as well as any pending or on-going:

(1) reviews, investigations, proceedings, restrictions, discipline or disputes at any other hospitals or health care facilities;

(2) changes in an applicant's or member's health (including mood disorders and substance abuse) which may impact on their ability to practice or expose patients or others to risk of harm; and

(3) information regarding any criminal investigation, charge, plea, proceeding, disposition, undertaking, fine or sentence, whether under appeal or review.

(xi) Perform any other duties or responsibilities delegated by the MAC.

13.7 Executive Committee

(a) **Purpose.** The purpose of the Executive Committee of the Medical Advisory Committee shall be to act for the Medical Advisory Committee when it is impracticable for the whole of the Medical Advisory Committee to act.

(b) **Composition.** The Executive Committee of the Medical Advisory Committee shall be comprised of:

(i) the chair of the Medical Advisory Committee;

(ii) the vice-chair of the Medical Advisory Committee;

(iii) a minimum of one other individual who is a member of the Medical Advisory Committee who has been appointed by the Medical Advisory Committee.

(c) **Chair.** The Chief of Staff shall be the chair of the Executive Committee of the Medical Advisory Committee.[40]

13.8 Medical Quality Assurance (MQA) Committee Terms of Reference (Sub-Committee of the Medical Advisory Committee)

(a) **Purposes.** The purposes of the MQA Committee are to:

(i) **QCIPA Quality of Care Committee.** Act as a, "Quality of Care Committee" pursuant to the *QCIPA*.

(ii) **Improve Quality of Health Care.** Carry on activities for the purpose of studying, assessing or evaluating the provision of healthcare, with a view to improving or maintaining the quality of healthcare, or the level of skill, knowledge and competence of the persons who provide healthcare.

(iii) **Morbidity and Mortality Framework.** Provide a morbidity and mortality review framework, designed to reduce deaths and promote continuous learning amongst the Professional Staff.

(b) **Membership.** The MQA Committee shall include the MAC members who are physicians or their designates omitting any external participants, guests, and presenters. The CEO, Vice President of Medical Affairs, Director of Risk

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40 *Public Hospitals Act (Ontario) Regulation 965* section 2(3)(c).

Management, Director of HIM and the Chief Nursing Officer will also sit on the MQA Committee.

(c) **Responsibilities.** Responsibilities of the MQA shall include the following:

(i) **Function as QCIPA Quality of Care Committee.** Function as a Quality of Care Committee as legislated in *QCIPA*, and in connection therewith, review or delegate a review of matters that may give rise to significant quality of care concerns, including specifically:
(1) an occurrence involving an unexpected death or serious bodily harm;
(2) an occurrence or series of occurrences that have the potential to result in death or serious bodily harm; or
(3) an occurrence of series of occurrences that have the potential to result in harm to a number of patients.

(ii) **Receive Information.** Depending on the matter to be reviewed, the Committee may seek or receive information/reports from any staff member, committee and/or external person/entity.

(iii) **Facilitate Improvements.** Review factors that may contribute to preventable deaths in a learning environment and look for opportunities to improve patient care and outcomes.

(iv) **Develop Flagging Process.** Develop a reporting process that flags morbidity and mortality cases to appropriate physician chiefs/groups and Medical Affairs for review and monitors morbidity and mortality data for the organization.

(v) **Report to Improve Quality of Care.** Report findings and recommendation to Hospital management or physician groups for the purpose of furthering the quality of care at the Hospital.

(vi) **Develop Improvement Implementation Plans.** Develop a communication plan around clinical findings and quality improvement recommendations.

(vii) **Monitor Trends.** Monitor trends that may be indicative of areas needing improvement or system changes and quality indicators from physician groups (Internal Medicine, Mental Health, and Family Medicine).

(viii) **Recommend Solutions.** The MQA Committee has the authority to recommend to any program or service the timely implementation of identified solutions to improve the quality of care.

(d) **Disclosure Parameters.** Disclosure of MQA Committee information shall be subject to and in accordance with the following:

(i) **Generally.** Except as explicitly permitted, quality of care information, specifically findings, opinions and conclusions of any *QCIPA* review cannot be disclosed.

(ii) **Hospital Management.** The MQA Committee may disclose, information pertaining to *QCIPA* reviews (this may include recommendations and any other information) to Hospital management, if the Committee considers it is necessary for the purpose of improving or maintaining the quality of healthcare provided at the Hospital.

(iii) **To Reduce Significant Risk.** The MQA Committee may disclose, internally or externally, *QCIPA* review information if necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons. Other than this one exception, information is not allowed to be disclosed outside the facility.

(iv) **Coroner.** If the Hospital is conducting a *QCIPA* quality of care review based on the request of the Coroner, the Coroner's office is permitted to be advised of:

(1) **Facts.** The facts stemming from the review.

(2) **Implemented Recommendations.** Recommendations the Hospital has implemented, or has begun to implement can be disclosed. For greater clarity, proposed recommendations are considered opinion and are therefore protected by *QCIPA* and cannot be disclosed.

For greater clarity, opinions, findings and conclusions of a *QCIPA* review are protected as quality of care information cannot be disclosed.

(v) **Patient.**

(1) **Facts.** Any facts learned during the course of a *QCIPA* review can be disclosed to the patient or their substitute decision maker, as facts are not considered to be quality of care information and are therefore not protected.

(2) **Implemented Recommendations.** Recommendations that are not implemented cannot be disclosed to the patient or patient's substitute decision maker, but once those recommendations have been implemented (i.e. steps have actually been taken), the actions taken can be disclosed.

For greater clarity, opinions, findings and conclusions are protected as quality of care information cannot be disclosed.

(e) **Critical Incidents.** In the event of a critical incident (see Policy - Patient/Visitors Safety Reporting System as set out in the related Schedule), the Director of Risk Management will determine if a review is to be designated for protection under QCIPA. The Director of Risk Management is accountable to report critical incidents and the subsequent changes implemented to the MQA Committee. The legislation also requires that the MAC receive this information. This mandated information will be provided during the MAC portion of the committee meeting. Any discussion protected under *QCIPA* must occur during the MQA Committee portion.

(f) **Accountability.**

(i) **Minutes.** Minutes of the MQA Committee shall be subject to and in accordance with the following:
(1) kept separate from the MAC minutes and shall not include details of case reviews or root cause analysis, but shall include quality of care recommendations, if any;
(2) shall not include information that would and/or could identify patients, families or caregivers.

(ii) **QCIPA Documentation.** All documentation or reports prepared for the MQA Committee under *QCIPA* shall be:
(1) clearly marked as such; and
(2) returned at the end of the meeting.

(iii) **Reports.** All MQA Committee reports will also be returned. Copies will not be kept by members and can be accessed through the MQA Committee site for review.

(g) **Meeting Frequency.** The MQA Committee shall meet monthly and at the call of the chair.

(h) **Quorum.** Quorum shall be a majority of the members of the MQA Committee.

13.9 Regional Pharmacy and Therapeutics (PandT) Committee Terms of Reference[41] (Sub-Committee of the Medical Advisory Committee)

(a) **Purpose.**
(i) Advises on all matters relating to the use of pharmaceuticals and other therapeutic agents within the Windsor-Essex Hospitals.
(ii) Maintains and approves a Regional Formulary of medications and therapeutic agents for use within the hospitals, including conditions and/or criteria for use where appropriate, which reflects rational, evidence-based, safe and cost-effective therapy.
(iii) Develops and maintains policies and procedures related to the safe and effective use of medications, related devices, and other therapeutic agents.

(b) **Values.**

(i) **Evidence-based decision making.** The committee ensures that decisions are supported with the best available evidence and in consideration of the experiences of its clinicians.

(ii) **Decision making criteria.** The committee ensures that decisions support effective therapy consistent with best practice and evidence considering

[41] Draft proposed Terms of Reference, currently under review.

the needs of clients, staff, other service providers, and prescribing medical professionals, as well as safety, effectiveness, cost and the need to avoid product duplication.[42]

(iii) **Regional Perspective.** The committee includes representation from Windsor Regional, Leamington District Memorial and Hôtel-Dieu Grace Hospital to ensure the committee structure is representative of each site.

(c) **Composition**[43]

(i) The physician members and site leads are selected by the individual Professional Advisory Committees (PAC) of each institution. The physician Chair of the Regional P&T Committee is a shared appointment by all 3 member hospitals for a term of 3 years. Other members are chosen by the applicable health care professions (nursing, pharmacy etc.).

(ii) Membership of P&T will include physician, nursing, pharmacy, allied health representatives and others. Each sub-committee shall have at least one member of the P&T Committee as part of the sub-committee membership.

(iii) The committee has the authority to consult any member of the medical or health professional staff to act in an advisory capacity.

(d) **Appointment of Regional Chair.** A search committee with representation from each site (Chiefs of Staff) along with the Vice-President, Clinical Support Services and the Regional Pharmacy Director and Regional Clinical Pharmacy Manager will be formed to appoint the physician Chair. Qualities sought in the physician Chair role include: Active member of the Medical Staff; evidence-based medicine experience; effective meeting skills; excellent communication skills; represents an area of practice with a high utilization of medications; and previous experience on the P&T Committee.

(e) **Role of Regional Chair.**

(i) Helps to set the agenda and calls bi-monthly meetings as required; calls meetings to order and maintains meeting decorum.

(ii) Communicates with Program Medical Directors and Program Directors to ensure complete representation.

(iii) Holds members accountable for regular attendance to maintain quorum.

(iv) Consults with Chief of PAC when further medical input is required on motions and recommendations.

(v) Calls for motions and in the event of a tie vote, will cast the deciding vote.

(vi) Sits as a member of each site's PAC (or a delegate of the Chair).

(f) **Responsibilities of Members.**

(i) Provide peer review on behalf of the program they represent on submissions to the Committee.

(ii) Review the agenda package and reference materials prior to the meeting including scoring of formulary proposals.

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42 Accreditation Canada Medication Management Standards 2010.

43 See the Regional Pharmacy & Therapeutics Committee StructureSchedule.

(iii) Bring forward any medication-related initiatives within their programs for review by the Committee prior to implementation.
(iv) Represent their discipline at the meetings on a consistent basis. If unable to attend the meeting, a delegate is nominated as appropriate.
(v) Communicate P&T decisions (once approved) back to their departments in a timely manner.
(vi) Members sharing a vote are to determine an effective means to meet this responsibility.

(g) **Conflict of Interest Disclosure.**

(i) All members will be required to declare any conflict of interest prior to participating in any discussions regarding formulary decisions. Conflict of interest declarations can be made at the meetings or prior to the meeting by notifying the Chair via fax or email. Each formulary review also contains conflict of interest declarations to be completed by the clinical submitting the request.
(ii) The P&T chair has the authority to determine if the circumstances or interests of a participant amount to a conflict of interest in respect to a submission that is before the committee. Participants shall not be involved in a submission in which they have sponsorship.
(iii) Names of members who have a conflict of interest shall be documented in the minutes.

(h) **Function.**

(i) To be responsible for managing the formulary system. A formulary system is defined as the ongoing process through which policies are established regarding the use of drugs, therapies, and drug-related products and identifies those that are most medically appropriate and cost-effective to best serve the health interests of a given patient population.[44]
(ii) To promote quality drug therapy through ongoing drug use evaluation that identifies opportunities to improve therapeutic outcomes, patient safety and cost-effectiveness.
(iii) To approve medications for addition/deletion to the Formulary, including conditions and/or criteria for use where appropriate, that reflects rational, evidence-informed, safe, and cost-effective therapy.
(iv) To develop and maintain the policies and procedures to outline the process for requesting changes (additions/deletions/criteria for use) to formulary.
(v) To develop and maintain the policies and procedures to outline the process for requesting non-formulary drugs.
(vi) To develop, maintain, and approve policies and procedures related to the safe and effective use of medications within each hospital.
(vii) To identify patient risk issues related to medication use and recommend strategies that promote the safe use of medications (e.g. high risk medications).
(viii) As appropriate, to review drug advisories/warnings from Health Canada/ pharmaceutical companies and to issue directives.

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[44] Tyler, L et al, ASHP Guidelines on the Pharmacy and Therapeutics Committee and the Formulary System. AJHP 2008; 65:1272-1283.

(ix) To inform and educate medical staff and other health care professionals within the hospitals regarding the optimal use of medications and therapeutic agents.
(x) To ensure regular evidence-informed reviews and approval of regional protocols that contain or are related to use of medications (including but not limited to criteria for use, treatment guidelines, clinical order sets, pre-printed orders, etc.).
(xi) To develop policies with respect to the role of pharmaceutical company representatives and medical science liaisons and define the provision of pharmaceutical samples, indirect or direct funding support and education programming regarding formulary and nonformulary medications.
(xii) To review reports from the P&T sub-committees.

(i) **Meeting and Minutes.**
(i) The committee shall meet at least five times per year: September, November, February, April and June. Additional meetings by videoconference may be called at the discretion of the chair if needed.
(ii) The committee shall maintain a permanent record of its proceedings and actions.

(j) **Quorum.** A majority of the membership will constitute a quorum with not less than 50% of physician membership present.

(k) **Accountability (reporting).** The P&T Committee reports to each site's Advisory Committees and also informs the relevant Nursing and other Health Professional Advisory Committees of approvals and other decisions made that will affect practice.

(l) **Sub-committees of the P&T Committee.**
(i) There are **six sub-committees** that report directly to the Regional P&T: Formulary, Medication Use Evaluation, Medication Safety, Medication Policies, Order set and Antimicrobial Stewardship Committee. The chair and a co-chair from each of the sub-committees attends the Regional P&T Committee.
(ii) These sub-committees will meet five times a year on the off months of P&T: August, October, January, March and May.
(iii) All items to be considered for the sub-committee meetings need to be submitted at least two weeks before the sub-committee meetings.

13.10 Infection Prevention and Control Committee (IPACC) Terms of Reference (Sub-Committee of the Medical Advisory Committee)

(a) **Purposes.** The purposes of the IPACC are to:

(i) **Infection Prevention and Control.** Function as the central decision and policy-making body for infection prevention and control at the Hospital.[45]

[45] See Provincial Infectious Diseases Advisory Committee (PIDAC): Best Practice for Infection Prevention and Control Programs in Ontario: In All Health Care Settings (MOHLTC - September, 2008).

(ii) **Provide Guidance.** Provide structure, direction, decision-making communication and administrative support to the Infection Prevention and Control programs of which the major goal is the prevention and control of infections for patients, visitors and health care providers. Actions must be guided by sound scientific principles, research and current information.

(iii) **Serve as Role Models.** The IPACC and its members should act as advocates and role models for the program and for practicing infection prevention and control best practices.

(b) **Membership.** Membership on IPACC shall be subject to and in accordance with the following:

(i) Chair: physician, epidemiologist or microbiologist.
(ii) Term of two years.
(iii) Members should include:
  (1) Infection prevention and control professional(s);
  (2) Infection prevention and control physician (or the medical director in non-acute facilities);
  (3) Occupational health representative;
  (4) Public health representative;
  (5) Environmental services representative;
  (6) Senior nursing representative(s) from key clinical programs;
  (7) Senior medical representative(s).

  Other members might also include:
  (1) specialist in microbiology;
  (2) pharmacy representative;
  (3) central equipment reprocessing area(s) representative;
  (4) operating room representative;
  (5) epidemiologist;
  (6) infectious diseases representative;
  (7) Quality assurance/risk management representative.

(c) **Responsibilities.** The IPACC is responsible for:

(i) Review and approval the annual goals of the IPAC program;
(ii) Evaluating the effectiveness of the activities developed under the IPAC program;
(iii) bringing to the attention of senior administration issues with compliance with relevant legislation;
(iv) ensuring that the infection prevention and control recommendations and standards of the Ministry of Health and Long-Term Care, Canadian Standards Association, Public Health Agency of Canada and specific accrediting bodies and other recognized organizations are being followed in the health care setting; advocating for resources necessary to accomplish the goals of the program; and
(v) Patient safety/risk management/quality assurance.

(d) **Meeting Frequency.** The IPACC shall meet as required.

(e) **Quorum.** Quorum shall be a majority of the members of the IPACC.

(f) **Accountability:**

(i) Written detailed agenda prepared and circulated at least five working days prior to meeting.

(ii) Minutes of each meeting will be recorded and verified as correct at the following meeting.

(iii) Minutes will show conclusions, recommendations, actions, evaluations and Most Responsible Person.

Copy of minutes and reports will he provided after each meeting to the following: Executive operations committees; Program Directors; Managers; and Infection Prevention and Control Committee members.

(g) **Reporting.** The IPACC Chair shall report to the MQA Committee as deemed appropriate. Recommendations will be brought forward for approval. The MQA Committee will in turn bring these recommendations forward to the MAC for approval. The Chair will then communicate data and analyses to the appropriate service at the IPACC level. The Chair will monitor actions and results and provide the MQA Committee an update report on outcomes.

SCHEDULE: DEFINITIONS AND INTERPRETATION

1. **Definitions:**

Whenever used in the Professional Staff Rules and Regulations, unless there is something in the subject matter or context inconsistent therewith, the following words and terms shall have the following meanings:

Active Staff	Active staff of the Hospital.
Admitting Department	The Hospital's admitting department.
Affiliation Agreement	The agreement between the Hospital and the University of Windsor and the University of Western Ontario regarding their joint relationship with respect to patient care, teaching, and research.
Associate Staff	Associate staff of the Hospital.
Board	The board of directors of the Hospital.[46]
By-law	Any by-law of the Hospital from time to time in force and effect, including the Administrative By-laws and the Professional Staff By-laws.[47]
CEO	Means, in addition to 'administrator' as defined in section 1 of the *Public Hospitals Act (Ontario)*, the president and chief executive officer of the Hospital.
Chief of Staff	The Hospital chief of staff appointed by the Board to serve as such.[48]
Clinical Lead	The Physician or Dentist appointed by a Program Medical Director to take responsibility for a defined Hospital Service within a Program.[49]
CME	Continuing medical education.

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46 Section 8.1 of the Administrative By-law details the Board's composition.

47 *Public Hospitals Act (Ontario)* section 12(1) requires the Hospital to pass by-laws as prescribed by *Public Hospitals Act (Ontario) Regulation 965*. *Public Hospitals Act (Ontario) Regulation 965* section 4 in turn, requires the Hospital to pass by-laws in relation to the management and administration of the Hospital and to provide for the organization and duties of the Medical Staff. Sometimes both the by-laws relating to management and administration of the Hospital and the by-laws related to the organization and duties of the Medical Staff are combined in one by-law, but more typically, they are divided into two separate by-laws, as is the case here.

48 See article 8 of the Professional Staff By-laws for further detail.

49 See section 7.9 of the Professional Staff By-laws for the duties of Clinical Lead.

College	The relevant regulatory body, as the case may be, including for examples: the College of Physicians and Surgeons of Ontario ("CPSO") and the Royal College of Dental Surgeons of Ontario.
Consultant / Consultation	Professional Staff Member ("Consultant") who is qualified by both experience and training to provide an opinion on the condition in question ("Consultation").
Covering Professional Staff Member	Professional Staff Member to whom the MRP transfers care of a of a patient in his/her absence.
Credentials Committee	Means the City Wide Joint Credentials Committee, a Sub-committee of the Medical Advisory Committee, tasked with reviewing all applications and re-applications for privileges or changes to privileges at the Hospital and as centralized and harmonized with Windsor Regional Hospital.[50]
CPD	Continuing professional development.
CPSO	College of Physicians and Surgeons of Ontario.
DNR	Do not resuscitate.
ECT	Electroconvulsive therapy.
Health Information Management Department	The Hospital's health information management department.
Hospital	Hôtel-Dieu Grace Healthcare and/or, depending on the context, the hospital facilities located at 1453 Prince Road, Windsor, Ontario and any other facilities operated by Hôtel-Dieu Grace Healthcare.
Hospital Management Regulation	*Public Hospitals Act (Ontario) Regulation 965*.
IPACC	Infection Prevention and Control Committee.
Medical Advisory Committee	The medical advisory committee appointed by the Board and constituted in accordance with the *Public Hospitals Act (Ontario)*.[51]
MRP	Most responsible professional. This is the Professional Staff Member who co-ordinates the care of the patient.
MQA	Medical Quality Assurance Committee

50 See section 13.6 of these Rules and Regulations for further detail about the Credentials Committee.

51 See *Public Hospitals Act (Ontario)* section 35 and *Public Hospitals Act (Ontario) Regulation 965* section 7.

MOHLTC	Means the Ministry of Health and Long Term Care.
OHIP	Means Ontario Health Insurance Plan.
P&T Committee	Regional Pharmacy and Therapeutics Committee.
patient	Unless otherwise specified, any in-patient or out-patient of the Hospital.
President	Means the president of the Hospital.
Privileges	The privileges granted to members of the Professional Staff related to the admission of in-patients, registration of out-patients, and the diagnosis, assessment and treatment of in-patients and out-patients.
Professional Staff Appointment	The appointment of a professional staff member to a Program in the Hospital within the categorization of active, associate, courtesy, temporary, honorary, consulting, term, senior clinical fellow, locum tenens, and/or telemedicine and educational staff.
Professional Staff Association	The organized body of voting members of the medical staff of the Hospital, as prescribed by the *Public Hospitals Act (Ontario)*.
Professional Staff / Professional Staff Member	Those physicians, dentists, and extended class nurses who are appointed by the Board and who are granted specific privileges to practice medicine, dentistry, respectively, or with respect to extended class nursing who are not employed by the Hospital and to whom the Board has granted privileges to diagnose, prescribe for or treat patients of the Hospital.
Program	Has the meaning given in Rules and Regulations section 1.2 and may refer to the Mental Health Additions Program, the Brain and Behaviour Program or the Consult Service Program, being the three Hospital programs established by the Board.
Program Medical Director	The physician appointed by the Board to be responsible for the professional standards and quality of medical care, diagnosis and treatment rendered by the members of that program in the Hospital.[52]
QCIPA	Means the *Quality of Care Information Protection Act, 2016*.

[52] See Professional Staff By-law article 7 for more detail about Program Medical Directors.

Rules and Regulations	These rules and regulations.
Service	A clinical unit of the Professional Staff responsible for providing a defined Hospital Service within a Program under the responsibility of a Clinical Lead appointed by a Program Medical Director.
Supervisor	Means a Physician or Dentist, as the case may be, who is assigned the responsibility to oversee the work of another member of the Professional Staff.[53]
Vice President, Medical Affairs	Means the physician employed by the Hospital who reports to the CEO (in contrast to the Chief of Staff and Program Medical Directors who report to the Board).

2. **Rules of Interpretation.** The following rules of interpretation shall apply to these Rules and Regulations:

   (a) **Number.** Unless the context requires otherwise, words importing the singular include the plural and vice versa.

   (b) **Gender.** Unless the context requires otherwise, words importing gender include all genders.

   (c) **Include, Etc.** Whenever the words "include," "includes" or "including" (or similar terms) are used they are deemed to be followed by the words, "without limitation."

   (d) **Statute References.** Any reference in these Rules and Regulations to any statute or any section thereof shall, unless otherwise expressly stated, be deemed to be a reference to such statute or section as amended, restated or re-enacted from time to time.

   (e) **Days.** References to days are in reference to calendar days.

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[53] See article 4 of these Rules and Regulations and section 4.2(c)(iv) of the Professional Staff By-laws for further detail about Supervisors.

SCHEDULE: POLICY REVIEW REQUIREMENTS

1. Chart Completion Policy - available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=3afb8f54-c4f4-4fa1-bb1f-c5e3cfa1cf85&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16

2. Conflict of Guidelines for Interactions Between HDGH and Industry Partners - available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=a37afce6-8712-400b-97ac-77ec04ad57bf&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16

3. Consent to Diagnostic Therapeutic Policy - available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=cecf4fd2-0a6a-438c-86b2-93f8a829ccae&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16

4. Corporate Health and Safety Policy - available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=f5de05f5-8b92-4071-926f-a36370aceb48&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16

5. Dangerous Abbreviations Policy - available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=ba839f03-09b1-4988-90f4-84a2f5e73a7c&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16

6. Electronic Authentication of Dictated Reports Policy - available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=a8de96cd-bef3-4734-b8d8-6ed26f62c150&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16

7. Ethics Consultation Policy - available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=7154d6ae-0573-4b4f-ac86-4fe67c9e59e6&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16

8. High Alert Medications Policy - available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=9ba3b72d-16f3-4440-a111-0658370c556d&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16

9. Media Relations Policy - available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=b6d545cb-f787-44b9-8a51-2d747c97dcf1&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16

10. Medication Incident Reporting Policy - available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=8912d5c5-6f37-4676-8fd4-56b5b7213652&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16

11. Medication Use Policy – available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=98be7442-fab5-43f8-8ccb-aa74cc0afbf3&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16
12. Patient/Visitor Safety Reporting System - available at:

http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=1911ab7c-5a47-43fc-8a6b-2425d1f58814&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16

13. Physician Assistant and Supervising Physician Policy - available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=e47556ae-481d-42e9-b87a-4ea90e285169&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16

14. Privacy Policy - available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=19f8f9fb-b147-4d4d-b508-1521f571b9b9&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16

15. Responding to Requests for Medical Assistance in Dying Policy - available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=9283ec7d-3825-47c7-984c-ff7433f03098&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16

SCHEDULE: CONFIDENTIALITY AGREEMENT

CONFIDENTIALITY AGREEMENT

I understand that within the scope of my work and/or affiliation with Hotel-Dieu Grace Healthcare (HDGH), I will have access to confidential information.

Definitions:

"Confidential information" means any oral, written or electronic data or information existing now or in the future relating to the operations and management of HDGH which is treated by HDGH as confidential and to which access is granted or obtained by the below named individual, and may include personal information and/or personal health information.

"Personal health information" with respect to an individual, whether living or deceased, means information concerning the physical or mental health of an individual; information concerning or collected in relation to any health service provided to the individual or information concerning the donation by any individual of any body part or bodily substance of the person. Personal health information is included in the definition of personal information.

"Personal information" means information about an identifiable individual, but does not include the name, title or business address or telephone number of an employee of the organization.

1. During my work and/or affiliation with Hotel-Dieu Grace Healthcare, I may have access to information relating to patients, medical staff, employees, volunteers and other individuals which is of a private and confidential nature. I will only access confidential information as necessary for the direct performance of my duties and responsibilities.

2. At all times, I shall respect the privacy, confidentiality and dignity of patients, employees, volunteers and all individuals associated with HDGH.

3. I shall treat all HDGH administrative, financial, patient, and employee records as confidential, and I will protect such information from improper disclosure. I shall not collect, use, alter, copy or disclose any confidential information without appropriate authorization. If I am unsure whether I have the authorization to access, use or disclose confidential information, I agree to seek clarification on this issue from my supervisor or HDGH provided privacy contact . I acknowledge that this obligation does not apply to information that is in the public domain.

4. I will be responsible for my misuse or wrongful disclosure of HDGH confidential information and for my failure to safeguard my access codes or other access authorization. I understand that my failure to

comply with this Agreement may result in immediate termination of my access privileges to HDGH systems.

5. Violations of this agreement and/or HDGH policies and procedures include, but are not limited to the following examples:

   - accessing confidential information that I do not require for the purpose of fulfilling my duties and responsibilities to HDGH;
   - misusing, disclosing without proper authorization, or inappropriately altering personal information or personal health information;
   - disclosing to another person my user name and/or password or failing to adequately protect my password.

6. I shall only access, process, and transmit confidential information using authorized hardware and software, or other authorized equipment, as required by the duties of my role at HDGH.

7. I understand that I will have access to health information systems where HDGH is not the host or system owner. I shall only access information through these systems necessary to service the patients of HDGH. I will abide by the user agreements HDGH has in place with external providers.

8. I understand that HDGH will conduct periodic audits to ensure compliance with this agreement and its privacy policy. I understand that my privileges to access confidential information are subject to periodic review, revision and discontinuance if appropriate.

9. I understand and agree to abide by the conditions outlined in this agreement, and I acknowledge that they will remain in force even after I cease to be affiliated with HDGH.

10. I also understand that, should any of these conditions be breached, I may be subject to corrective action including, but not limited to, termination of my employment or affiliation at HDGH. I also understand that there is a formal procedure for investigation of complaints and that I will have the opportunity to appeal the findings of an investigation.

11. I am aware of HDGH policies and procedures regarding privacy, confidentiality and security of personal information and I understand that it is my responsibility to be familiar with these policies and procedures and to comply with their provisions.

Name (Please Print)_____ Signature _____

Name of Witness (Please Print)_____ Signature _____

Date: _____

DISCLAIMER: When referencing any HDGH policies, users are requested to consult the online policy manual to ensure access to and use of the most current, up-to-date and accurate policy. HDGH cannot guarantee any printed policy is current or accurate, if there is a discrepancy between the electronic policy and a paper copy, the electronic copy prevails.

SCHEDULE: ASSOCIATE STAFF REVIEW REPORT

Hôtel-Dieu Grace Healthcare
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ASSOCIATE STAFF REVIEW

Name of HDGH Associate Staff Member	
Name of HDGH Assigned Supervisor	
Review Period	

Associate Professional Staff Information:
Clinical Practice
Brief Description of the Associate's medical activities:

Clinical Knowledge/Responsibility	**Above average**	**Average**	**Below Average**	**NA**
Establish and maintain clinical knowledge, skills and attitude appropriate to their practice				
Perform a complete and appropriate assessment of a patient				
Use preventative and therapeutic interventions effectively				
Demonstrate proficient and appropriate use of procedural skills, both diagnostic and therapeutic				
Seek appropriate consultation from other health professionals, recognizing the limits of their expertise				
Prompt response to pages				
Participates in administration and leadership roles, as appropriate				
Attendance at meetings/Committee participation				

Communicator/Collaborator	**Above average**	**Average**	**Below Average**	**NA**
Ability to develop rapport, trust and ethical relationships with patients and families				
Accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues and other professionals				
Accurately convey relevant information and explanations to patients and families, colleagues and other professionals				

Develop a common understanding on issues, problems and plans with patients, families and other professionals to develop a shared plan of care				
Convey effective oral and written information about a medical encounter				
Participate effectively in an inter-professional healthcare team				
Effectively work with other health professionals to resolve inter-professional conflict				

Managers in Healthcare	**Above average**	**Average**	**Below Average**	**NA**
Participate in quality improvement and patient safety initiatives				
Recognize the importance of just allocation of healthcare resources, balancing effectiveness, efficiency and access with optimal patient care				

Professional Development/Continuous Learning	**Above average**	**Average**	**Below Average**	**NA**
Maintain and enhance professional activities through ongoing learning				

Strengths/Areas of Improvement (Please Describe):

Summary Recommendation (Please choose the most appropriate statement)

On-Target for Recommendation without reservation for Active Staff privileges □
Recommend with reservations (please explain below) □
Not on-target for recommendation for full active staff privileges □
(please explain below)

Comments:

SUPERVISOR SIGNATURE:_____
Date:_____

SCHEDULE: PROFESSIONAL STAFF RETURN FROM LEAVE OF ABSENCE POLICY AND FORM

Guiding Principles

Factors to consider when granting a leave of absence:

- The reason for the request;
- The length of leave requested;
- Whether leaves of absences have been granted in the past to other members in similar circumstances;
- Whether granting the current request for leave will set a precedent, and what this implies;
- Whether the hospital will reasonably be able to arrange for coverage during the leave and whether patient care will be compromised;
- Other information provided by the member and the Chief of Staff/Chair of the Medical Advisory Committee (or most appropriate clinical leader); and
- Any other factors deemed appropriate.[54]

Factors to consider at the time of reinstatement after a leave of absence:

- Whether the timing of the reinstatement coincides with what had been planned (e.g. early return may not be possible if contracts have been secured with other clinicians to provide coverage);
- Whether it is safe for the member to return and whether patient care could be compromised;
- Whether the member meets all criteria for re-appointment to the Professional Staff;
- Whether the hospital is able to accommodate any supports, restrictions, or requirements for supervision or monitoring of the member.
- Other information provided by the member and the Chief of Staff/Chair of the Medical Advisory Committee (or most appropriate clinical leader).
- Any other factors deemed appropriate.[55]

LEAVE OF ABSENCE REQUEST FORM

Name:		Privileges : Department:	
Date:		Chief / Department Head	

Reason for Request for Leave of Absence:

_____

_____

_____

_____

Length of time requested (please note the hospital cannot grant a leave longer than 12 months):

☐	

54 OHA Professional Staff Credentialing Toolkit, Pg. 90.

55 OHA Professional Staff Credentialing Toolkit, Pgs. 90-91.

	I am requesting a set period of leave of absence of _____ days / months (circle one).
☐	I am requesting an indefinite leave of absence on the understanding that it cannot be for longer than 12 months. **Please note: You must reapply for re-appointment three (3) months before your return from leave.**

Please list your clinical responsibilities at the hospital:

_____
_____
_____
_____

Please list your administrative responsibilities at the hospital:

_____
_____
_____
_____

Please include your recommendations for coverage during your requested leave:

_____
_____
_____
_____

Contact information for you during your requested leave:

1st Number:_____ 2nd Number:_____ 3rd Number: _____

Email Address: _____ Home Address/Postal Code/City _____

Signature & Date:_____ _____

SCHEDULE: ADVANCED HEALTHCARE DIRECTIVES AND POWER OF ATTORNEY FOR PERSONAL CARE

Available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=a7327544-cc1f-458e-9247-d727819ab45c&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16

SCHEDULE: CONSENT FOR TREATMENT/SERVICES POLICY

Available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=cecf4fd2-0a6a-438c-86b2-93f8a829ccae&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16

SCHEDULE: CODE WHITE – PERSONS DEMONSTRATING AGGRESSIVE BEHAVIOUR

Available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=578f252b-4d32-4143-95ca-799e9554cbd2&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16

SCHEDULE: PATIENT/VISITORS SAFETY REPORTING SYSTEM POLICY

Available at: http://hdghpolicy.esclhin.on.ca/Content/ViewContent.aspx?contentId=1911ab7c-5a47-43fc-8a6b-2425d1f58814&ContentTypeId=f5f77589-c44e-4869-9779-d2965bc84a16