MEDICAL STAFF RULES

FOR THE

VANCOUVER ISLAND HEALTH AUTHORITY

(ISLAND HEALTH)

DRAFT ~~10~~11, VERSION 3

Board Approved, May 2006
Board Amended, August 2007 Board Amended, November 2009
Board Amended, March 2010
Board Amended, June 2016
Board Amended, September 2016
Board Amended, November 2016
Board Amended, March 2017

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DEFINITIONS:

Note: Capitalized terms not otherwise defined below shall have the meaning provided in the VIHA Medical Staff Bylaws (link attached)

Administrator On-Call	The Administratorsenior administrator who acts as the primary organizationalVIHA contact, in case of emergency, outside of regular working hours. This person and who can be contacted viareached through the VIHA main switchboard.
Appointment	The process by which a physician, dentist, midwife or nurse practitioner becomes a member of the medical staff of the Vancouver Island Health Authority (VIHA).
Best Possible Medication History (BPMH)	A "snapshot" of the patient's actualcurrent medication use, obtained through a systematic process of interviewing the patient/ or family and reviewingreview of at least one other reliable source of information. DocumentsThe BPMH documents all current prescription and non-prescription medication information, including: drug name;, dose (or amount/ or volume));), route;, frequency; and duration.
Board of Directors	The governing body of the VIHA.
Bylaws	The Vancouver Island Health AuthorityVIHA Medical Staff Bylaws.
Chief Executive Officer (CEO)	The person engaged by the VIHA to provide leadership to the health authority and to carry out the day-to-day management of the facilities and programs operated by the health authority in accordance with the bylaws, rules and policies of the Vancouver Island Health Authority.
Chief Medical Officer (CMO)	The Senior Medical Administrator appointed by the Chief Executive Officer (CEO). Current title is Executive VP and Chief Medical Officer.), currently titled Vice President Medicine, Quality & Academic Affairs
Chief Nursing Officer (CNO)	A Registered Nurse employed by VIHA who has health-authority wide responsibility and is accountable for providing senior leadership and strategic direction for the professional practice of nursing and allied health.
Computerized Provider Order Entry (CPOE)	The process of order placement of orders into the Electronic MedicalHealth Record (see below) by a care provider or designated medical staff member using either single orders or groups of orders (electronic clinical order sets) or single orders by the provider or designated clinician.).
Dentist	A member of the medical staff duly licensed by the College of Dental

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	Surgeons of B.C. and entitled to practice dentistry in British Columbia.
Department	A major component of the medical staff composed of members with common clinical or specialty interest.
Department Head	The member of the medical staff appointed by VIHA, and responsible to the CMO or CNO, as appropriate, to lead the clinical, academic, quality-improvement and governance activities of a Department.
Disruptive Behaviour	Inappropriate behaviour that interferes with respectful operations in the workplace, team and patient communication, team morale, or patient care and satisfaction by hindering or preventing staff from carrying out their professional responsibilities to the best of their abilities.
Division	A component of a Department composed of members with a clearly defined sub-specialty interest.
Division Head	~~The~~A member of the Active Medical Staff, appointed by ~~the~~a Department Head to ~~oversee and be responsible for~~lead the clinical, academic, quality-improvement and governance activities of a Division.
Electronic Health Record (EHR)	~~A collective Electronic Medical Record~~An IHealth-based summative electronic document replacing the traditional health record of a patient~~/~~, client, or ~~a population of patients/clients. Specifically~~resident. The EHR is specifically designed to support ~~users~~clinicians by providing ~~accessibility~~access to complete and accurate health data, alerts, reminders, clinical decision support ~~systems~~, links to ~~medical knowledge,~~relevant clinical databases and other aids.
Electronic Medical Record (EMR)	A ~~single patient's~~summative electronic ~~medical~~document replacing the traditional health record~~.~~ of a patient in a private practitioner's office or clinic setting. An EMR contains ~~a patient's~~patient medical information that can ~~access~~be accessed electronically ~~rather than through a paper chart~~and linked with other databases, such as an EHR.
Enhanced Medical Staff Support (EMSS)	An administrative team ~~which~~that supports medical leaders by ~~addressing Practitioner~~assisting them to address professional practice issues in the workplace ~~and~~by enhancing ~~the~~their capacity ~~and ability of medical and other leaders across the organization to~~to identify, understand, manage and resolve these issues effectively.
Executive Medical Director (EMD)	A member of the Medical Administration, appointed by VIHA, who usually works in a dyad-partnership with an executive administrator and reports directly ~~reporting~~ to the ~~Chief Medical Officer, having current credentialing~~CMO. The EMD is responsible for leadership in operations, quality-improvement or medical-governance. Credentialing and privileging as a Practitioner in Island Health is an asset, but not a requirement.

Facility	A health care facility as defined by the *Hospital Act* and its *Regulation* of B.C.
Fellow	A physician who has completed specialist residency training ~~currently~~ recognized by a university program ~~and~~who has been accepted by ~~the Vancouver Island Health Authority~~VIHA for further training in a clinical discipline.
Freedom of Information and Protection of Privacy Act ("~~FIPPA~~FOIPPA")	~~The Freedom of Information and Protection of Privacy Act ("FIPPA")~~A provincial act ("FOIPPA") that regulates the information and privacy practices of "public bodies" ~~including~~such as provincial government ministries, local governments, crown corporations, local police forces, ~~schools, and~~ hospitals ~~to name a few~~and schools.
Health Authority Medical Advisory Committee (HAMAC~~)*~~)	The advisory committee to ~~the Vancouver Island Health Authority~~VIHA on medical, dental ~~and~~, midwifery and nurse practitioner practice *matters*, as described in Article 8 of the Medical Staff Bylaws ~~(Bylaws).~~.
Health Record	A ~~collection,~~ digital or ~~hardcopy,~~hard-copy version of the ~~clinical information pertaining to a patient's~~patient medical ~~history~~chart.
IHealth	~~IHealth is the~~The platform ~~Island Health~~VIHA uses to access, edit and manage a ~~patient's electronic health record (~~patient EHR~~).~~.
Interdisciplinary Team	~~Every healthcare member who is~~The integrated group of practitioners, nurses and allied health professionals involved ~~with or impacts~~in the care of ~~the~~a patient.
~~Island Health~~Local Medical Advisory Committee (LMAC)	~~Vancouver Island Health Authority (VIHA).~~ A local advisory committee to the HAMAC on medical, dental, midwifery and nurse practitioner clinical practice and governance matters, as described in Article 8 of the Medical Staff Bylaws.
Local Quality and Operations Committee (LQOC)	A local committee composed of medical and administrative leaders responsible for quality assurance, quality improvement, and operational efficiency and effectiveness at a given site.
Medical Care	For the purposes of this document, medical care includes the clinical services provided by physicians, dentists, midwives and nurse practitioners.
Medical Director	A member of the Medical Administration~~, reporting~~ who reports directly to ~~the~~an Executive Medical Director~~, holding active Medical Staff~~ and who normally holds Privileges as a member of the medical staff.
Medical Lead	A member of the Medical Administration~~, reporting~~ who reports directly to ~~the~~a Medical Director~~, holding active Medical Staff~~ and who normally holds Privileges as a member of the medical staff.

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Medical Planning and Credentials Committee (MPCC)	A sub-committee of the HAMAC responsible for making recommendations on credentialing, privileging, appointment, reappointment and regular review of members of the Medical Staff.
Medical Staff	The physicians, dentists, midwives and nurse practitioners who have been appointed to the medical staff, and who hold a permit to practice medicine, dentistry, midwifery, or nursing as a nurse practitioner in the facilities and programs operated by VIHA.
Medical Staff Association	The ~~body~~practitioner-advocacy arm of the Medical Staff, comprised of all members of the ~~Medical Staff~~medical staff, whose professional interests are represented by their elected officials as outlined in ~~the relevant article~~ Article 11 of the Bylaws.
Medical Staff Rules (Rules)	The Rules approved by the Board of Directors governing the day-to-day management of the medical staff in the facilities and programs operated by VIHA .
Medical Student	A physician~~ ~~in~~ ~~training who has not yet received a degree ~~of Doctorate of~~to practice Medicine.
Midwife	A member of the medical staff duly licensed by the College of Midwives of B.C. and entitled to practice midwifery in British Columbia.
Most Responsible Practitioner (MRP)	The Practitioner who undertakes the overall responsibility for the management and coordination of care ~~of the patient~~for a patient or resident admitted to a VIHA owned or operated facility.
Nurse Practitioner	A member of the medical staff duly licensed by the College of Registered Nurses of British Columbia and entitled to practice as a nurse practitioner in British Columbia.
Oral and Maxillofacial Surgeon	A dentist who holds a specialty certificate from the College of Dental Surgeons of British Columbia authorizing practice in oral and maxillofacial surgery.
Patient-~~Centered~~Centred Care	~~Patient-Centered care is deemed to occur when~~Care that places the ~~interests of~~ patient ~~well-being are paramount to medical~~and family at the centre of clinical decision making to ensure that the patient's voice, wishes and well-being are fundamental to the plan of care.
Physician	A member of the medical staff duly licensed by the College of Physicians and Surgeons of B.C. and entitled to practice medicine in British Columbia.
Practitioner	A physician, dentist, midwife or nurse practitioner who is a member of the medical staff of VIHA .

Primary Department	The Department to which a member of the medical staff is assigned according to training, and the specialty in which the member delivers the majority of care to patients.
Privileges	A permit to practice medicine, dentistry, midwifery or nursing as a nurse practitioner in the facilities and programs operated by the health authority and granted by VIHA to a member of the medical staff, as set forth in the *Hospital Act and its Regulation*. Privileges describe and define the scope and limits of each practitioner's permit to practice in the facilities and programs of the health authority.
Program	An ongoing care-delivery system under the jurisdiction of the VIHA for coordinating a specified type of patient care.
Regulation	The Regulation made under the authority of the *Hospital Act*.
Section	A component of a Division composed of members with clearly defined sub-specialty interests.
Senior Medical Administrator	The physician, appointed by the CEO, responsible for the coordination and direction of the activities of the medical staff, currently titled Vice President Medicine, Quality and Academic Affairs, also known as the Chief Medical Officer. This physician serves as the director of medical practice within VIHA.
Temporary Privileges	A permit to practice in the facilities and programs operated by VIHA that is granted to a member of the medical staff for a specified period of time in order to provide a specific service.
Regulatory ~~Colleges~~College	The discipline-specific regulatory ~~college~~body for a member of ~~Medical~~the medical staff.
Resident	A ~~practitioner~~ physician ~~-~~in~~-~~ training who has ~~achieved and~~ received a ~~Doctorate of Medicine~~medical degree and who is undertaking additional ~~qualification~~specialty training in a ~~Facility~~facility owned or operated by VIHA.
Section Head	~~The~~A member of~~-~~ the Active Medical Staff appointed by ~~the~~a Division ~~Head~~ or ~~alternatively~~ Department Head to ~~oversee~~lead the clinical, academic, quality-improvement and ~~be responsible for the~~ governance activities of a Section.
~~Trainees~~Trainee	~~Those Physicians, Dentists or Midwives~~A licensed practitioner who has applied to and ~~have~~ been accepted by ~~Island Health~~VIHA for further clinical training.
~~-~~Unprofessional Behaviour	~~Disruptive behavior is a pattern of inappropriate behavior that interferes~~

~~with the functioning and flow of the workplace. It hinders or prevents faculty and staff members from carrying out their professional responsibilities, can interfere with team and patient communication, team morale, and may adversely affect patient care and satisfaction.~~
Behaviour that contravenes the code of professional conduct of a practitioner's regulatory college or professional association, or Island Health policy.

~~Article 1 –~~ Article 1: Good Medical Practice

1.1 PREAMBLE

~~Each~~The Medical Staff ~~member is a core contributor~~are essential to the delivery of ~~healthcare~~effective care to patients and their families~~. As respected members of~~ across the ~~healthcare team, the~~Vancouver Island Health Authority (VIHA). The Medical Staff ~~must abide~~maintain their respected status by modeling the ethics, values and professionalism expected by society, ~~Island Health,~~ regulatory bodies, VIHA, and other healthcare ~~professionals~~team members.
~~Island Health~~

The care Medical Staff provide is guided by the principles and practice of continuous quality improvement. VIHA has endorsed the Triple Aim of the Institute for ~~Health~~Healthcare Improvement (IHI) as a guiding principle. Its three major elements ~~are focused~~focus on improving the health ~~care~~ of the population, reducing the cost ~~of health care~~ per capita of healthcare and improving both the patient ~~and~~ experience of care. VIHA has also embraced as a 4th guiding principle that of improving the provider experience~~. The daily care Medical Staff provide~~, which is ~~guided by the principles and processes of continuous quality improvement.~~ included in the VIHA concept of a 'quadruple aim'.
~~Island Health~~VIHA has adopted a ~~core~~ set of core values (CARE) that reflect the organization's ~~interest in serving~~commitment to serve the ~~various~~different communities ~~in their~~across its diverse ~~geographic domains:~~ geography; Courage~~,~~ ~~—~~to do the right thing; Aspire~~,~~ ~~—~~ to the highest level of quality and safety; Respect—to value each individual and bring trust to every relationship; and Empathy ~~(C.A.R.E.), represent the essence of~~ —to give the kind of care we would want for our loved ones. VIHA has adopted a learning organization ~~that embraces~~philosophy embracing creativity, innovation and excellence in service delivery.

~~1.2 APPLICATION~~

1.2 APPOINTMENT AND ACCOUNTABILITY

The Board of Directors (the Board) is ultimately accountable for the quality of medical care~~,~~ and provision of appropriate resources~~,~~ in the Facilities and Programs operated by Island Health. This accountability extends to the Chief Executive Officer (CEO~~)~~), who is the ~~Board of Directors'~~Board's representative, as outlined in Section 3(1) of the *Hospital Act Regulation.* The Board ~~of Directors~~ grants Privileges to appropriately ~~–~~qualified Medical Staff members and employs the CEO to conduct the day-to-day affairs to ensure effective operation of the Facilities and Programs operated by ~~Island Health~~VIHA.

The Hospital Act Regulation requires the Board to organize a Medical Staff ~~is required to be organized~~ in conformity with the Medical Staff Bylaws~~,~~ (Bylaws), the Medical Staff Rules (Rules) and ~~Island Health's~~VIHA's policies and procedures.

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Members of the Medical Staff are required to adhere to, and are offered the protections of, the B.C. *Freedom of Information and Protection of Privacy Act* (FOIPPA) and other applicable legislation respecting personal privacy.

These ~~Medical Staff~~ Rules ~~("Rules")~~ are established by the ~~Island Health~~ Board ~~of Directors~~ upon the recommendation of the Health Authority Medical Advisory Committee ~~("~~(HAMAC~~")~~) pursuant to Article 12 of the ~~Medical Staff~~ Bylaws. ~~The Rules are considered necessary for the proper conduct of the Medical Staff and address the requirements of the *Hospital Act* and the *Hospital Act Regulation*.~~ The Rules govern the relationship between VIHA and the Medical Staff, and address requirements laid out in the *Hospital Act* and its *Regulation*. The Rules also address the accountability Medical Staff members have for their day~~-~~to~~-~~day ~~management of the medical Staff~~practice in the Facilities and Programs operated by Island Health. The Rules apply to all members of the Medical Staff whether they are independent practitioners, contracted practitioners or employees.

The members of the Medical Staff are accountable~~, as outlined herein,~~ for the quality of medical care they provide in the Facilities and Programs operated by ~~Island Health.~~VIHA. The Rules detail the responsibilities of Medical Staff in an organization committed to ~~excellence of~~excellent care. The Rules promote positive interactions with colleagues, medical and administrative ~~leadership~~leaders, other healthcare professionals and other team members ~~and assure~~. This ensures appropriate support for team members to work to their full professional scope of practice while meeting individual and organizational goals and objectives ~~and goals~~.

~~1.3 PATIENT CENTRED CARE~~

~~Patient-centred care puts patients at the forefront of their health and care, maximizes their control over their own choices, helps them make informed decisions and supports a partnership between individuals, families and healthcare service providers.~~
~~Medical Staff at Island Health include their patients in their own healthcare journey by striving to:~~

~~(1) create a Patient-centred care model that incorporates self-management; shared and informed decision-making; enhanced experience of health care; improved information and understanding and the advancement of prevention and health promotion activities;~~

~~(2) make patients, families and caregivers partners in health care, supported and encouraged to participate and make decisions in their own care to the degree to which they want to be involved in decision making about their care, participation in quality improvement, research and teaching and healthcare design; and~~

~~(3) include in their practice the core Principles of patient centered care including dignity; respect; information sharing; participation and collaboration.~~

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~~Practitioners serve an essential societal role as professionals dedicated to the health and care of others. A practitioner's professional identity reflects contemporary society's expectations, which include clinical competence, a commitment to ongoing professional development, promotion of the public good, adherence to ethical standards, and values such as integrity, honesty, altruism, humility, respect for diversity, and transparency with respect to potential conflicts of interest. It is also recognized that, to provide optimal patient care, medical staff must take responsibility for their own health and well-being and that of their colleagues.~~
~~Island Health recognizes the CanMEDS and CanMEDS Family Medicine frameworks as an established standard that outlines the competencies Medical Staff require to effectively meet the health care needs of the people they serve. The CanMEDS framework may be used as a benchmark at Island Health for assessing professional behaviour, competence and quality. The CanMEDS framework groups competencies under seven roles:~~

~~(A) Medical Expert (the integrating role)~~

~~As Medical Experts, physicians integrate all of the CanMEDS Roles, applying medical knowledge, clinical skills, and professional values in their provision of high quality and safe patient centred care. Medical Expert is the central physician Role in the CanMEDS Framework and defines the physician's clinical scope of practice.~~

~~(B) Communicator~~

~~As Communicators, physicians form relationships with patients and their families* that facilitate the gathering and sharing of essential information for effective health care.~~

~~(C) Collaborator~~

~~As Collaborators, physicians work effectively with other health care professionals to provide safe, high-quality, patient-centred care.~~

~~(D) Leader~~

~~As Leaders, physicians engage with others to contribute to a vision of a high-quality health care system and take responsibility for the delivery of excellent patient care through their activities as clinicians, administrators, scholars, or teachers.~~

~~(E) Health Advocate~~

~~As Health Advocates, physicians contribute their expertise and influence as they work with communities or patient populations to improve health. They work with those they serve to determine and understand needs, speak on behalf of~~

~~others when required, and support the mobilization of resources to effect change.~~

~~(F) Scholar~~

~~As Scholars, physicians demonstrate a lifelong commitment to excellence in practice through continuous learning and by teaching others, evaluating evidence, and contributing to scholarship.~~

~~(G) Professional~~

~~As Professionals, physicians are committed to the health and well-being of individual patients and society through ethical practice, high personal standards of behaviour, accountability to the profession and society, regulation, and maintenance of personal health.~~

~~Additional information and resources relating to the CanMEDS framework is available at www.royalcollege.ca/rcsite/canmeds-e.~~

~~1.4 PRACTITIONER COMPACT~~

~~The development of a practitioner compact that clarifies roles, expectations and accountabilities can help guide relationships between practitioners and operational leaders. Island Health and Medical Staff intend to jointly develop an Island Health Practitioner Compact through an inclusive, collaborative and transparent process.~~

~~1.5~~1.3 PATIENT PRIVACY & CONFIDENTIALITY

Medical Staff have a duty of confidentiality to ~~Island Health~~ patients. ~~FIPPA~~FOIPPA applies to the collection, use, disclosure, and care of patients', clients' and residents' personal information ~~of patients~~, as well as ~~non- patients, such as~~that of employees and volunteers. Use or disclosure of personal information about an individual cannot occur without that individual's consent unless the information ~~falls within~~meets specific exceptions~~.~~ as outlined in FOIPPA. Individuals ~~also~~ have the right to review and ask for corrections to their personal information.

~~The following are best practice guidelines for Medical Staff:~~

~~(1) Protect the personal health information of patients.~~

~~(2) Provide information to patients about the reasons for the collection, use and disclosure of their personal health information.~~

~~(3) Be aware of your patient's rights with respect to the collection, use, disclosure and access to their personal health information; ensure that such information is recorded accurately.~~

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(4) Avoid public discussions or comments about patients that could reasonably be seen as revealing confidential or identifying information.

(5) Disclose your patient's personal health information to third parties only with their express consent

(a) in accordance with a court order (search warrant), taking care to review the warrant and release only the information specified in it

(b) in accordance with a court order (subpoena), ensuring the records produced are sealed and in accordance with the court order

(c) as provided for by statute as a duty to report (for example, reporting a child in need of protection, reporting gunshot and stab wounds)

(d) in circumstances requiring a public safety exception, in which the physician must have reason to believe (and obtain sufficient information from law enforcement)

(i) that there is a clear risk to an identifiable person or group of persons

(ii) that there is a risk of serious bodily harm or death (including serious psychological harm), and

(iii) that the danger is imminent.

(6) When acting on behalf of a third party, take reasonable steps to ensure that the patient understands the nature and extent of your responsibility to the third party.

(7) Upon a patient's request for a copy of the Health Record, refer the patient or a third party to the Island Health's Health Records Department.

If Medical Staff plan to use electronic means of communication to transmit patient personal information, they will take reasonable steps to ensure the transmission of that information is secure and will obtain the patient's informed consent electronic communication is planned for this purpose.

Medical Staff will comply with applicable legislation, Regulatory College guidelines, and Island Health policies governing personal information patient privacy and confidentiality, all as may be amended from time to time.

1.6 STANDARDS OF PROFESSIONAL BEHAVIOUR

(A) CanMEDs/CanMEDs FP Competency Framework

See the CanMEDs definition of the role of professional outlined in Article 1.3.

(B) Principles of Partnership Governing Professionalism

~~(1) The Principles of Partnership Governing Professionalism, as set forth in Appendix X, represent the expectations of professional conduct for all Medical Staff within Island Health in order to protect and acknowledge the right of each member to work in a safe, cooperative and respectful health care environment.~~

~~Each Medical Staff member granted Island Health Privileges is required to read and acknowledge the Principles of Partnership Governing Professionalism. This is required upon reapplication for appointment to the Medical Staff.~~

~~(C) Medical Staff as Advocates for System Improvement~~

~~(1) Medical Staff are in an ideal position to identify needs for change and improvements within the health system. When advocating within Island Health Facilities, Medical Staff will:~~

~~(a) Maintain transparency, professionalism, and integrity~~

~~(b) Work within approved channels of communication~~

~~(c) Discuss concerns, suggestions, and recommendations calmly~~

~~(d) Provide an informed perspective, and attempt to include the perspectives of patients and other healthcare professionals~~

~~(e) Use evidence to help persuade others.~~

~~(f) Remain open to alternative suggestions or solutions, and try to build on areas of consensus~~

~~(D)~~1.4 RESPECTFUL WORKPLACE POLICY

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1.4.1 ~~Island Health~~VIHA and its Medical Staff are committed to ensuring that all individuals, whether patients, clients, residents ~~and~~, visitors or staff are~~:~~

- treated with dignity and respect, free from discrimination and harassment~~;~~ and
- supported in managing workplace ~~differences and~~conflict.

~~(1)~~1.4.2 VIHA and its Medical Staff are committed to providing a ~~work~~workplace and service environment that respects and promotes human rights and personal dignity. To this end, Medical Staff are required to conduct themselves, and to be treated, in accordance with the ~~Island Health~~VIHA Respectful Workplace Policy.

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~~Island Health is committed to providing:~~

~~(2) Education about human rights, harassment, bullying, appropriate behaviour in the workplace and dispute resolution;~~

~~(3) A process for informal resolution of respectful workplace complaints;~~

(4) A process for the reporting and investigation of respectful workplace complaints, including discrimination and discriminatory harassment; and

(5) Interventions to strengthen the relationships and work of teams.

(E) Effects of Unprofessional Behaviour

Unprofessional behaviour of Medical Staff may adversely affect the delivery of quality patient care by, among other things:

(1) Deflecting a Medical Staff member's attention from the patient, therefore impairing clinical judgment and performance;

(2) Increasing the likelihood of errors by leading others to avoid the unprofessional Medical Staff member, to hesitate to ask for help or clarification of orders or to make suggestions about patient care;

(3) Undermining patient's confidence in the Medical Staff member or hospital;

(4) Creating a working environment that undermines recruitment and retention efforts for Medical Staff and other staff;

(5) Affecting the reputation of individual Medical Staff members, the interdisciplinary care team and Island Health; and/or

(6) Impairing the abilities for medical administration to work effectively.

1.7 REPORTING & MANAGING UNPROFESSIONAL BEHAVIOUR

(A)1.5.1Purpose

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(1) To encourage the prompt identification of behaviour that is contrary to the Principles of Partnership Governing Professionalism, the Island Health Respectful Workplace Policy, or the CMA Code of Ethics, as applicable, which may adversely affect the delivery of safe patient care.

(2) To provide a transparent process for dealing with unprofessional conduct by members of the Medical Staff, including all Medical Staff credentialed and privileged within Island Health, whether in a clinical or administrative capacity.

(B) Reporting Unprofessional Behaviour: Principles

(1) Where standards of professional behaviour are not observed, the matter will be addressed as outlined below in a consistent, equitable and timely manner.

(2) All reported unprofessional behaviour, received orally or in writing, will be considered carefully.

(3) Where perceived unprofessional behaviour is observed or experienced within a

clinical setting, it should be reported to the relevant Division Head or Department Head, or to the Chief of Staff. If a perceived lack of psychological or physical safety exists, Medical Staff or staff may report concerns to the CEO, the CMO or through the Safe Reporting Policy.

(4) Where perceived unprofessional behaviour is observed or experienced within a medical administration setting, it should be reported to the Chief Medical Officer. If perceived lack of psychological or physical safety exists, Medical Staff or staff may report concerns to the CEO or through the Safe Reporting Policy.

(5) Reports of unprofessional behaviour will be investigated as soon as possible, usually within 2 weeks.

(6) Reprisals against the reporter(s) of unprofessional behaviour as well as the subject of a complaint will not be tolerated and may result in discipline.

(C) Reporting Unprofessional Behaviour: Safe Reporting Policy

(1) The Island Health Safe Reporting Policy provides that a review of the conduct of any person associated with Island Health, including a member of the Medical Staff, may be initiated through the Island Health Safe Reporting Officer or General Counsel. The Safe Reporting Policy does not replace established procedures for managing unprofessional conduct as set out herein.

(2) The review of an allegation involving a member of the Medical Staff will be conducted in consultation with the CMO. Should the CMO be subject to the investigation, the review will be conducted in consultation with the CEO. In cases where the cancellation, suspension, restriction or non-renewal of Privileges may be warranted, the recommendation will be forwarded jointly to the Chair of the Board of Directors and to the CEO who will involve the HAMAC in accordance with Article 11 of the Bylaws.

(D)1.5.1Managing Unprofessional Behaviour

Unprofessional behaviour is not tolerated in Island Health. Management of such behaviour requires a transparent investigative, evaluative and reporting system, known to the practitioner from the outset and supporting a culture of just application of consequence. Detailed processes to support the fair and timely management of unprofessional behaviour are set forth in Appendix [x] to these Rules.

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(E)1.5.1Managing Issues of Clinical Competence

Oversight of professional competence includes professionalism, judgement, and performance to expected standards within the Department. Assessment of competence is much more than the evaluation of the technical skill (See Article 1.3).

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~~Concerns arising from clinical practice which suggest possible deficiencies of competence are a key obligation of Medical Staff Leadership to both monitor and address. Due process in the means of assessing and evaluating competence are described in Appendix (XXX) to these Rules.~~

~~(F)1.5.1 Whistle Blowing Policy~~

~~(1) Island Health expects all Practitioners to report Perceived Wrongdoing using appropriate channels. Alternatively, individuals may report Perceived Wrongdoing to the Designated Central Point of Contact (DCPC) as defined within the Whistle Blower policy, or the independent third party reporting service.~~

~~(2)1.5.1.1 Reports under this policy must be made in good faith and based on reasonable grounds.~~

~~The Whistle Blowing policy is set forth in Policy 5.5.12P.~~

~~1.8~~1.5 ~~TRANSITION~~ TRANSITIONS OF CARE & PATIENT SAFETY

~~The responsibility for patient care is outlined in Article 5 of the Bylaws. Only Medical Staff with Privileges to admit patients can be the MRP. Nothing in this Article of the Rules relieves any Medical Staff member of his/her responsibility to support the MRP and to assist in the provision of medical care to the patient in a proactive way.~~

~~(A)~~1.5.1 Most Responsible Practitioner (MRP)

~~(1)~~ The ~~Most Responsible Practitioner (~~MRP~~)~~ is ~~identified initially as~~ the Medical Staff member who agrees to ~~accept~~be the primary care provider for a patient ~~within~~admitted to a ~~site or licensed~~VIHA-operated Facility ~~under his/her medical direction.~~. The MRP ~~should be~~is established on the basis of ~~who has the~~whose scope of practice is best suited to ~~the admitting medical problems.~~treat the most responsible diagnosis at the time of admission. The MRP is determined either prior to the admission ~~(~~for planned surgical admission or subspecialty ~~planned~~ intervention~~/care),~~ and treatment, or at the time a decision to admit is made in the Emergency Department.

1.5.1.1 The responsibility for patient care is outlined in Article 5 of the Bylaws. Only Medical Staff with Privileges to admit patients can be the MRP. ~~The MRP exists within a shared care role in delivery of health and treatment services to patients.~~

1.5.1.2 The MRP is the Practitioner responsible for ~~directing and coordinating the~~the overall care of a patient admitted to a Facility. The MRP works within a multidisciplinary team to deliver care and treatment to the patient.

1.5.1.3 Consultation is a process whereby the MRP or another consultant asks a colleague for advice or help in managing the care of a patient. Those consulted are expected to collaborate expeditiously in providing this assistance.

~~(2)~~1.5.1.4 If the patient's medical ~~problems warrant the involvement of additional specialty services, the MRP is involved in the coordination and facilitation of care~~

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~~and cooperation among~~condition warrants consultation with other members of the Medical Staff, the MRP coordinates and facilitates that care.

~~(3)~~1.5.1.5 During a patient's ~~Facility stay~~admission, the role of the MRP may be transferred ~~(Article 1.8 (D)(4)),~~ based upon ~~on~~ the changing acuity and nature of the patient's medical condition ~~of the patient~~.

~~(4)~~1.5.1.6 The MRP is responsible ~~for~~to:

~~(a)~~(i) ~~Accepting~~Accept patients for admission from the Emergency Department (ED) or ~~in~~ following acceptance of a transfer ~~of~~ care request from ~~a requesting~~another Practitioner~~.~~;

~~(b)~~(ii) ~~Completing~~Complete and ~~documenting~~document a full assessment for admission, ~~providing admission~~including a full history, physical examination and continuing-care orders~~.~~;

~~(c)~~(iii) ~~Working~~Work collaboratively with team members to develop a Best Possible Medication History (BPMH) and ~~ordering~~order appropriate medications~~.~~;

~~(d)~~(iv) ~~Providing~~Provide daily care for acute patients and care as appropriate for ALC patients, completing progress notes and overseeing the patient's care, either directly or through an on-call group. ~~For~~Responsibility for Residential Care patients ~~please see~~is addressed in Article 3~~.~~;

~~(e)~~(v) ~~Communicating~~Communicate with the patient ~~or medical representative~~ and the patient's primary-care Practitioner regarding medical conditions, tests and planned consultations ~~planned~~, including test results. ~~With patient consent, this~~This information may be shared with ~~agreed to~~other parties~~.~~ only with the patient's consent or as required by law;

~~(f)~~(vi) ~~Working~~Work collaboratively with healthcare team members~~.~~;

~~(g)~~(vii) When necessary, ~~clarifying~~clarify and resolve apparent treatment or management conflicts among care providers~~.~~;

~~(h)~~(viii) ~~Facilitating~~Facilitate and ~~coordinating~~coordinate discharge to the community and ~~ensuring~~ communication with the primary-care Practitioner ~~in the community~~, where present, as well as with community ~~home~~ support teams~~.~~; and

~~(i)~~(ix) ~~Ensuring~~Ensure medication reconciliation and prescriptions are available upon discharge until the patient can be followed in the community.

~~(B)~~1.5.2 Most Responsible Practitioner for Admissions from the Emergency Department (ED)

~~(1)~~1.5.2.1 ~~In this instance,~~When a patient requires admission from the ED, the emergency physician ~~requests a colleague~~(EP) will request a Practitioner, either directly or through that Practitioner's on-call group, to assume the role of MRP~~.~~. This request will be based on ~~scope of practice and the patient's presenting medical issues.~~selecting the practitioner or service that customarily manages patients with the most-responsible diagnosis necessitating the admission.

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~~(2)~~1.5.2.2 A Practitioner with admitting privileges must be ~~able~~available personally or through an on-call service to accept the MRP role ~~of MRP and if~~. Once a patient has been accepted, ~~is thereafter primarily responsible~~ the Practitioner assumes primary responsibility for the care and disposition of the patient up to ~~and including any request for a~~ the time that transfer-of-care ~~to~~ is accepted by another ~~Medical Staff member being made and accepted~~Practitioner or the patient is discharged back to the community.

~~(3)~~1.5.2.3 If, prior to accepting MRP but after personally seeing and assessing the patient ~~in consultation~~, the Practitioner does not believe he/she is the most appropriate Practitioner for the role of MRP, the Practitioner may liaise directly with an alternate service or with the referring ~~Practitioner~~EP regarding ~~assumption of~~ the ~~role of admitting~~most appropriate Practitioner or service to assume MRP responsibility.

~~(4)~~1.5.2.4 Where ~~persistent~~an admission disagreement ~~exists~~persists, the EP shall contact the Head(s) of the Division ~~Head and/~~(s) or Department ~~Head and/~~(s) to which the Practitioners in dispute are assigned. If this is not possible or unsuccessful, the EP should contact the Site ~~Medical Director &~~ Chief of Staff (or designate~~) will be notified to resolve and determine the immediate delegation of MRP.~~). After hours, a Senior Medical Director is also available to the VIHA Executive-on-Call, who can provide assistance. At the earliest opportunity during ~~normal~~regular working hours the incident ~~will~~shall be ~~reported to~~reviewed by the appropriate Department Head(s), who will ~~review the decision and~~ determine ~~if it requires~~next steps to prevent further ~~evaluation, recording~~conflict, up to and including reporting the incident to the HAMAC Chair and CMO if necessary.

~~(C)~~1.5.3 Most Responsible Practitioner for Care in ~~Clinics and~~ Out-Patient Facilities

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~~(1)~~1.5.3.1 Only Practitioners with appropriate Privileges may write orders ~~on~~for patients who require medical or mental-health treatment in ~~clinics or~~out-patient Facilities operated by ~~Island Health~~VIHA.

~~(2)~~1.5.3.2 ~~These Practitioners are~~ A Practitioner wishing to treat a patient in an out-patient Facility must be designated as the MRP and ~~retain~~maintain responsibility for all subsequent care ordered and carried out in the ~~clinic or licensed~~ Facility, whether or not the ~~MRP~~Practitioner is physically present at the site.

~~(3)~~1.5.3.3 In exceptional circumstances, the CMO or designate may authorize a non-privileged Practitioner to order or provide care in ~~a clinic or licensed~~an out-patient Facility, as determined on a case-by-case basis.

~~(D)~~1.5.4 Consultations and Transfer of Care~~:~~

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~~(1)~~1.5.4.1 ~~A~~The MRP should make a consultation request ~~should be made~~ directly ~~from~~

~~the MRP~~ to the consulting Practitioner. In the case of an urgent or emergent situation, another healthcare professional may request the consultation on behalf of the MRP.

~~(2)~~1.5.4.2 A consultation is a request for a professional opinion, advice or support in the management of a patient. The ~~consultation will include a personal~~ consultant shall provide an in-person evaluation of the patient, a review of all necessary documentation and the provision of a timely, dictated or legible report ~~in keeping with IHealth standards, where applicable, giving both opinions and~~, using the VIHA EHR wherever it is implemented. The evaluation should provide a clinical opinion, recommendations for management and/or treatment ~~as well as~~, and the basis for ~~that~~the advice given. The consulting Practitioner ~~will~~shall notify the MRP on completion of the consultation in a timely and mutually acceptable manner.

~~(3)~~1.5.4.3 A consultation may result in an opinion only or an expectation of continued management in the area of ~~special~~specialized knowledge being sought; this will be determined through a conversation between the MRP and consulting Practitioner. If the consulting Practitioner agrees to provide direct and continuing care to the patient for those aspects of care related to the consulting Practitioner's expertise, this ~~should~~shall be acknowledged directly in the patient's clinical record. Direct care includes ongoing evaluation and ~~assessment~~treatment of the patient's condition and communication with the patient ~~or medical representative and team, and/or~~, family ~~as consented and~~, MRP, other ~~healthcare professionals regarding~~Practitioners involved in the ~~area of specialized~~patient's care ~~provided~~and the multidisciplinary team, as appropriate.

~~(4)~~1.5.4.4 A transfer-of-care request is a direct Practitioner-to-Practitioner ~~request~~conversation to transfer MRP status or ~~other~~ specific ~~shared~~ care responsibilities to another Practitioner. Practitioners making such a request shall provide ~~in detail~~ a ~~summary~~detailed report ~~describing~~summarizing the care given to the patient up to the point of transfer, including orders, medications, and the ~~projected~~ care plan in place at the time of transfer. Transfer-of-care does not occur until the accepting Practitioner ~~signifies~~provides written or verbal acceptance ~~which is~~ documented in the patient health record.

~~(5)~~1.5.4.5 Reports~~:~~

~~(a)~~(i) All consultations and transfer-of-care ~~reports will~~documents shall follow best-practice guidelines ~~as~~ established by the Royal College of Physicians and Surgeons of Canada (~~RPSC~~RCPSC) ~~and~~or the College of Family Physicians Canada (CFPC~~) and~~). Where IHealth is implemented in a VIHA Facility, these documents must also meet or exceed ~~the expectations of Island Health as provided in~~ IHealth documentation standards. These reports are subject to practice audits to ensure compliance with documentation standards.

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(ii) Copies of reports must respect provincial and VIHA privacy and confidentiality guidelines. Recipients to be copied must be identified in the body of the report.

~~(b)1.5.1.1 Copies of reports must respect patient privacy and confidentiality guidelines. Recipients to be copied must be identified in the body of the report.~~

~~(6)~~1.5.4.6 Urgency~~:~~ of Consultation

~~(a)~~(i) ~~Urgent (~~To ensure timely information transfer and intervention, urgent (consultation within 12 hours~~ of the request~~) or emergent (consultation within two hours~~ of the request) consultations~~) requests for consultation must be made by direct Practitioner-to-Practitioner contact. The actual required response time is dependent on the condition of the patient. ~~This ensures timely transmission of relevant information and ensures timely intervention.~~

~~(E)~~1.5.5 Admission of Patients

~~(1)~~1.5.5.1 The care of every patient, whether admitted to an in-patient bed or cared for in an out-patient ~~(clinic)~~Facility, shall be directed ~~and authorized~~ by an appropriately privileged ~~Practitioner who will hold primary responsibility for the care of the patient. This Practitioner shall be identified as the MRP.~~MRP.

~~(2)~~1.5.5.2 Patients admitted ~~as an inpatient~~ for in-patient dental surgery ~~being provided~~ by a member of the Dentistry staff ~~Dentist~~ shall be admitted under the care of a ~~Physician member of the~~ physician or nurse practitioner on the Active Medical staff ~~with admitting Privileges~~ who shall ~~be~~act as the MRP. For ~~those~~day-surgery dental procedures, a complete, recently-documented medical history and physical exam performed ~~as day surgery, an accompanying recent history and physical~~ by a duly~~-~~licensed ~~Practitioner~~physician or nurse practitioner is an acceptable substitute, provided the documentation accompanies or precedes the patient to day surgery.

~~(3)~~1.5.5.3 A complete medical history and ~~complete~~ physical examination is required for all admitted patients ~~receiving scheduled or elective in-patient care at the time the patient is admitted and in an approved modality for the Electronic Health Record (EHR). Contents~~within 12 hours of ~~the~~ admission ~~history~~. In VIHA Facilities that have implemented the EHR, the history and physical must ~~conform to~~ be entered into IHealth ~~policy~~.

~~(4)~~1.5.5.4 Patients admitted through the ED or transferred ~~for~~to a higher ~~levels~~level of care must have an initial admission note that includes the presenting problem requiring admission, the results of physical examination and ancillary ~~examinations~~investigations, as well as an initial care plan provided by the ~~admitting~~ MRP or delegate. ~~A full~~In VIHA Facilities that have implemented the EHR, the initial

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admission ~~history conforming to IHealth policy~~note must be ~~dictated to the EHR within 24 hours of admission~~entered into IHealth.

~~(5)~~1.5.5.5 If a patient is readmitted to an acute-care Facility within two weeks for the same reason as for the previous admission, a new ~~partial history and physical exam~~admission note must be completed ~~to include pertinent~~, including new historical and physical findings ~~and at a minimum to include~~since the last admission, a review of allergies and medications, ~~review of symptoms, physical examination~~ and a mental status assessment.

~~(6)~~1.5.5.6 In circumstances ~~of~~requiring an emergency admission, where a Practitioner other than the MRP has provided holding orders, the MRP must provide ~~consolidated and updated~~complete admission orders within ~~24~~12 hours of the admission.

~~(F)~~1.5.6 Transfer of Patients

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~~(1)~~1.5.6.1 The MRP ~~should~~shall verbally contact the Practitioner to whom ~~he/she wishes to~~ care will be transferred. The transfer ~~care. The transfer of MRP status (other than "on-call") from one Practitioner to another shall be duly recorded on the Health Record.~~ of MRP status (other than following "on-call") from one Practitioner to another shall be duly recorded in the Health Record. This ~~is also applicable to~~includes transfers ~~when a patient is transferred~~ to another Facility. The MRP shall inform the receiving site ~~will be fully informed~~ about the patient's condition ~~by the MRP~~ and must be ~~aware of who~~ informed which Practitioner has agreed to accept MRP responsibility ~~for the patient's care. This will~~. The transfer shall be followed by ~~a~~an expedited written or dictated summary. ~~In~~In the case of inter-Facility transfers, the summary shall accompany or precede the patient.

~~(2)~~ If a ~~consulting~~ Practitioner wishes to withdraw from ~~involvement in~~ patient care after a ~~patient's~~duty of care ~~when their specific services are still required~~has been established, that ~~consulting~~ Practitioner ~~is required to~~must arrange for another Practitioner with appropriate qualifications to assume ~~this role. If the consulting~~that care. A Practitioner who cannot find another qualified Practitioner ~~who is~~ willing to assume care~~, they~~ must ~~inform the MRP.~~

~~(3)~~1.5.6.2 ~~Consultation~~meet with the appropriate Division ~~Head~~ or Department Head ~~will take place if there is a disagreement regarding the consulting Practitioner or MRP.~~ to arrange ongoing coverage. Failure to do so constitutes patient abandonment.

~~(4)~~1.5.6.3 ~~In those instances where~~Where a patient is transferred to another Facility for administrative rather than medical reasons (~~ie:~~e.g., lack of available beds at the sending Facility), the MRP, if not ~~following~~assuming the ~~patient to~~ MRP role at the new ~~location, shall ensure the transfer is completed in accordance with established policy and will contact~~ Facility, shall speak to the receiving Practitioner directly to

provide information regarding the plan of care. The Administrator ~~On~~ on-Call at the receiving site will coordinate ~~both inter-Practitioner~~this conversation~~, as required and~~ to ensure safe and timely access to necessary services.

~~(5)~~1.5.6.4 A competent patient, or their legal representative, has the right to request a change of Practitioner. That Practitioner shall cooperate in transferring responsibility for care of that patient to another Practitioner with appropriate Privileges who is acceptable to the patient. If an acceptable Practitioner cannot be found by the treating Practitioner, the appropriate Site Medical Director/Chief of Staff shall assist the patient in finding another Practitioner to ~~agree to continue to~~ provide care to the patient. If a willing Practitioner cannot be found, the appropriate Department Head, Division Head or delegate will discuss options with the patient. ~~Only upon provision of~~Until an alternate Practitioner ~~may~~has accepted responsibility for the patient, the Practitioner providing current care ~~provider cease care~~must continue to do so for the patient.

~~(G)~~1.5.7Repatriation from ~~Tertiary Centres~~a Higher-Level-of-Care Facility to a Referring Facility

~~(1)~~1.5.7.1 ~~Patients undergoing repatriation~~Before a patient is repatriated to a referring ~~care~~ Facility ~~require~~, clinical, operational~~,~~ and administrative ~~and medical~~ preparation ~~and~~ , including required documentation, must be completed.

1.5.7.2 Where repatriation ~~is~~occurs between two acute-care Facilities, verbal ~~Practitioner-to-Practitioner~~ communication between the sending Practitioner and the receiving Practitioner is required. ~~The~~Acknowledgment of this conversation and acceptance of the transfer ~~by the receiving Practitioner~~ must be documented in the Health Record by the sending and ~~the name of the~~ receiving ~~MRP recorded~~Practitioners.

~~(2)~~ At a minimum, a transfer note, but preferably a discharge summary, completed by the sending Practitioner~~.~~

~~(3)~~1.5.7.3 ~~A discharge summary/transfer note~~ must accompany the patient upon transfer~~,~~ either ~~within the EHR (preferential between acute-care sites) or~~ as a legible, signed and dated hardcopy delivered with the patient or, where both sites have deployed IHealth, by entry into the EHR.

~~(4)~~1.5.7.4 Medication reconciliation and review is a ~~necessary adjunct to~~required element of the accompanying documentation delivered with the patient undergoing repatriation.

~~(5)~~1.5.7.5 The sending Practitioner must provide sufficient notification ~~to accommodate~~, as outlined in VIHA standard-operating procedures, to enable operational planning for the repatriation.

~~(H)~~1.5.8Discharge of Patients

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~~(1)~~1.5.8.1 A discharge plan ~~should inform the provision of~~informs care planning from the time ~~of admission and should be updated regularly as part of daily care planning. Normally,~~a patient is admitted until discharge. The MRP shall document a discharge plan ~~should be documented in writing~~into the patient's health record within 24 hours of admission. The plan should be updated as part of daily care-planning.

~~(2)~~1.5.8.2 The MRP or ~~on-call~~ delegate on-call shall provide a discharge order and complete ~~the~~a discharge summary ~~in an~~using a discharge template approved ~~modality for the EHR compliant with IHealth documentation policy, including communication~~by HAMAC. The summary shall include information about the course in hospital, current and discontinued medications, follow-up plans, patient disposition ~~and any,~~ advance directives, and recommendations to ~~the~~ community Practitioners and healthcare professionals. The discharge summary shall conform to IHealth documentation policy in Facilities where IHealth has been deployed.

~~(3)~~1.5.8.3 A required component of the discharge process includes provision of follow-up instructions and specific post-discharge plan~~,~~ to the patient, caregivers and medical Practitioner. These instructions should include a list of all appointments made with consultants, any pending outpatient investigations, outstanding tests and any home and community care supports arranged or needing to be arranged.

~~(4) With the exception of uncomplicated, daycare or short-stay surgical procedure, a~~ A discharge summary is required for~~:~~

~~(a) All~~ all in-patient discharges ~~regardless of length of stay, except for uncomplicated obstetrics.~~

~~(b) All~~, all deaths~~;~~ and

~~(c)~~1.5.8.4 ~~All complicated~~all obstetrics and newborns~~.~~ cases, except for those patients with:

(i) An uncomplicated daycare or short-stay surgery;
(ii) An uncomplicated obstetrical delivery;
(iii) An uncomplicated neonatal admission; or
(iv) A short admission where HAMAC and the Board have approved an abbreviated discharge documentation process.

~~(5)~~1.5.8.5 For uncomplicated ~~obstetrics~~obstetrical admissions, the ~~prenatal record is considered to be~~British Columbia (BC) Antenatal Record Part 1 and 2 shall become an integral part of the patient record. The ~~BCRPC~~BC Labour~~, birth summary and newborn record~~ and Birth Summary Record, together with the BC Newborn Record Part 1 and 2 must be completed and placed in the health record by the ~~Physician/Midwife~~MRP and will form the discharge summary in uncomplicated deliveries.

~~(6)~~1.5.8.6 ~~For daycare and short-stay surgery, a~~A combined ~~operating~~operative report and discharge summary, including follow-up plans, is required for uncomplicated

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daycare and short- stay ~~uncomplicated~~ surgery and for uncomplicated surgical cases with a length of stay of less than 48 hours.

~~(7)~~1.5.8.7 To ensure continuity of care and patient safety, the discharge summary should be completed at the time of discharge but must be completed within two (2) days of discharge, with the expectation that Island Health will ensure the delivery of copies to appropriate recipients within two (2) days following completion.

~~(l)~~1.5.9 Reports

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~~(1) An operative report is required for all invasive procedures except those documented as part of a medical imaging procedure, laboratory medicine procedure, or minimally invasive procedure where a procedure note is required.~~

~~(2) A procedure note shall include description of procedure performed including condition of patient during and at conclusion of operative procedure, estimated blood loss and specimens removed.~~

~~(3)~~1.5.9.1 . The ~~combined~~ report must be dictated immediately upon completion of an operative or other high-risk procedure. If the operative report ~~and procedural report shall be documented~~will not be placed in ~~an approved format. Where the IHealth platform is in use,~~ the ~~report must be completed~~health record immediately after dictation, then a progress note must be entered in the ~~EHR. The operative report should include:~~health record immediately after the procedure to provide pertinent information to the next care provider(s).

~~(a) Identifying patient and provider information;~~

~~(b) Distribution of copies to the referring Practitioner and/or family Practitioner or others, as appropriate;~~

1.5.9.2 The operative report must contain, at a minimum:

(i) The patient's name and health-record number;
(ii) The name of the primary surgeon and assistant(s);
(iii) The names of Practitioners who should receive a copy of the report;
~~(c)~~(iv) Date and time of admission;
~~(d)~~(v) Date of procedure;
~~(e)~~(vi) ~~Preoperative~~ Pre-operative and post-operative diagnosis~~/indications~~;
~~(f)~~(vii) Proposed procedure~~;~~(s) and indications;

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~~(g) Post-operative diagnosis;~~

~~(h)~~(viii) Operative procedure(s) performed;
(ix) ~~Description of procedure performed including~~Operative complications, if any;

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(x) The patient's condition ~~of patient~~before, during and ~~at conclusion of operative procedure, estimated~~immediately after the operation;

~~(i)~~(xi) Estimated blood loss; and ~~specimens removed; and~~

~~(j) Post-operative complications, if any.~~

(xii) Specimens removed and their disposition (e.g., to pathology).

1.5.9.3 For medical-imaging and laboratory-medicine procedures, or for other minimally invasive procedures, a procedure note is required in lieu of an operative report.

1.5.9.4 Operative and procedural reports shall be documented in a VIHA-approved template and format. Where the IHealth platform is in use, the report must be completed in the EHR.

~~(4)~~1.5.9.5 A combined operative report and discharge summary including follow-up plans, is required for daycare and short- stay uncomplicated surgery and uncomplicated surgical cases with a length of stay of less than 48 hours.

~~1.9~~1.6 HEALTH RECORDS

~~(A)~~1.6.1 ~~Health records,~~Both paper-based and electronic~~,~~ Health records are those documents compiled by the medical and professional staff of Island Health to document care provided to patients~~/~~, clients and residents. The responsibility of ~~a Practitioner~~Practitioners to complete their component of a Health Record remains regardless of the format ~~by~~in which the Health Record is maintained. The **Clinical Documentation Policy** outlines the accuracy and integrity of clinical documentation ~~that is an individual responsibility~~required of Practitioners. All Medical Staff ~~will~~shall comply with ~~the Clinical Documentation Policy~~this policy.

~~(B)~~1.6.2 Medical Staff shall use Computerized Provider Order Entry (CPOE) to place, manage and monitor orders electronically in the Electronic Health Record (EHR) ~~as applicable. Island Health~~at all VIHA Facilities where CPOE has been implemented. VIHA is responsible ~~for providing~~to provide education and training for the use of CPOE and the EHR.

~~(C)~~1.6.3 Orders for Medical Treatment

~~(1)~~1.6.3.1 ~~All~~Only Practitioners with admitting or consulting Privileges may sign off or authenticate orders for medical treatment ~~shall be signed and/or authenticated~~in Facilities operated by ~~a Practitioner with appropriate Medical Staff Privileges.~~ VIHA.

~~(2)~~1.6.3.2 An order for medical care may be dictated over the telephone to a registered nurse, licensed practical nurse or registered psychiatric nurse. An order dictated over the telephone shall be documented over the name of the ordering Practitioner ~~and be signed and/or authenticated~~ by the person to whom ~~they are~~the order is

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dictated. The ordering Practitioner ~~shall~~ must sign the order in the paper health record or authenticate ~~such orders as soon as possible~~it in the EHR within 24 hours of the order having been dictated.

~~(3)~~1.6.3.3 ~~Telephone~~A Practitioner may give telephone orders ~~pertaining~~ to other professional staff in disciplines~~, e.g.~~ such as medical imaging, laboratory medicine, occupational therapy, physical therapy, respiratory therapy, dietary, or pharmacy, ~~etc., may be given by the medical Practitioner to a member of that discipline~~ who shall document and sign the orders in the EHR, or ~~on~~in the ~~Physicians Order Sheet for~~health record where paper-based ~~orders~~charts are in use, over the name of the ordering Practitioner.

~~(4)~~1.6.3.4 Paper-based orders may be faxed. ~~-~~Practitioners must sign off in the fax that they have specifically written or approved the orders submitted in this manner.

~~(5)~~ In an emergency a Practitioner may give verbal ~~orders for~~ treatment orders to other members of the care team who shall document and sign the order ~~into the EHR, or onto the chart for paper-based orders, over~~ on behalf of the ~~Practitioner's name per~~Practitioner. Following the ~~writer's name. The~~ emergency situation, the ordering Practitioner shall ~~authenticate such~~countersign these orders as soon as possible.

1.6.3.5 ~~All~~ In Facilities where CPOE is implemented, the Practitioner shall ensure the orders are entered into the EHR and authenticated by the ordering Practitioner.

~~(6)~~1.6.3.6 Orders for treatment shall ~~have the name, date, time, number (with the professional body's license number), and signature and/or authentication by a staff member of a professional practice group as defined~~only be given by members of a health profession identified in the Health Professions Act and in accordance with the standards of ~~the~~that member's College. ~~In the paper-based orders, this information shall be legibly written.~~Orders shall be legible, clearly identify the date and time of the order, the member's full name and College identification number, and signature or electronic authentication.

~~(7)~~1.6.3.7 Medication orders ~~will~~shall follow the ~~accepted~~ standards ~~according to Island Health policies with respect to legibility, accuracy, use of~~outlined in the VIHA Medication Orders policy . Orders shall be legible, accurate, contain only approved abbreviations, and ~~adherence~~adhere to VIHA's formulary policies ~~of the hospital~~.

~~(8)~~1.6.3.8 Practitioners prescribing medication shall comply with Section 19 of the Controlled Drugs and Substances Act~~,~~ (1996) and other federal and provincial legislation pertaining to the use of drugs.

~~(9)~~1.6.3.9 No drug, whether supplied by the ~~hospital~~VIHA or not, may be administered to a patient without an order from ~~an authorized health~~a Practitioner~~.~~ authorized to prescribe that drug. This may include Practitioners outside the scope of ~~this~~

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~~document~~these Rules, including ~~nurse practitioners~~nurses and pharmacists ~~as per local policy. All other medications, including investigational drugs, may be used as per existing policies.~~ .

~~(10)~~1.6.3.10 A Practitioner using Clinical Order Sets~~:~~, whether preprinted or prepopulated in the ~~Practitioner~~EHR, is responsible for signing ~~and/~~or authenticating ~~preprinted/prepopulated orders~~them.

~~(D)~~1.6.4 Progress Notes

1.6.4.1 Progress notes for acute ~~-~~care patients ~~should~~shall be documented by the MRP daily, ~~but~~or more frequently as determined by ~~changing~~ the evolving condition of the patient ~~conditions.~~ .

~~(1)~~1.6.4.2 Progress notes ~~should describe:~~shall document:

~~(a)~~(i) ~~Date~~The date and time of ~~service;~~assessment or intervention;
~~(b)~~(ii) Any material change in the patient's condition;
~~(i)~~(iii) Active monitoring, investigation and ~~measuring~~treatment, including the management of ~~–~~a problem list; and
~~(c)~~(iv) Any ~~revisions~~revision to the anticipated date of discharge, discharge plan or prognosis.

~~(2)~~1.6.4.3 Progress notes for Alternative-Level-of-Care (ALC) patients must be documented ~~as often as~~in response to a change in the patient's condition ~~warrants~~.

~~(E)~~1.6.5 Completion of Health Records

~~(1)~~1.6.5.1 Health records containing all relevant documents should be completed and validated by all involved Practitioners as soon as they become available. All Practitioners shall comply with the VIHA Health Records ~~must be completed according to policies that have been formally accepted~~Policy approved by HAMAC and ~~by~~ the Board ~~of Directors~~.

1.6.5.2 The ~~Health Record will~~health record may be ~~accepted for filing~~filed as incomplete only under the following extenuating circumstances ~~(extended~~:

(i) Medical Leave of Absence~~,~~ greater than three months;
(ii) Resignation~~,~~ from the VIHA Medical Staff;
(iii) Retirement~~,~~; and
(iv) Death~~) and only if the Physician is unable to complete the records assigned.~~ .

~~(2)~~1.6.5.3 If the ~~Practitioner responsible~~MRP is no longer available to complete the ~~chart~~health record(s~~),~~) due to circumstances outlined in Article 1.6.5.2 above, the appropriate Division Head, Department Head or Chief of Staff ~~will be responsible for reviewing~~shall review the record and ~~providing~~provide written authorization ~~for filing~~to file the Health Record as incomplete.

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~~(3)~~1.6.5.4 If the Practitioner is unable to complete and validate the Health Record because all relevant documents and reports are not available or completed, the Practitioner shall notify the Health Records Department ~~is to be notified~~directly.

~~(4)~~1.6.5.5 Prior to planned absences, the Practitioner shall complete all outstanding ~~patient~~health records. Practitioners who have notified ~~Medical Administration~~the Health Records Department in ~~advance of~~writing prior to their absence ~~shall~~will not ~~lose Privileges~~receive an administrative suspension for incomplete records identified during their absence. Outstanding records shall be completed within 14 days ~~after~~of the Practitioner's return.

~~(5)~~1.6.5.6 Locum tenens Practitioners (locum tenens) are responsible ~~for the completion of~~ to complete the Health Records of patients for whom they have been ~~caring for. Records~~ MRP during the locum-tenens period. The Practitioner the locum tenens replaced is responsible to complete health records left incomplete ~~shall be completed by the Medical Staff member replaced~~ by the locum tenens.

~~(6)~~1.6.5.7 ~~Written notification of failure to complete records shall be provided to~~ The Health Records Department shall provide the responsible Practitioner ~~by the Health Records Department. Within 14 days of issuance of this notice, the~~with written notification of incomplete health records. The Practitioner shall complete the identified records~~. A 7~~ within 14 days of this notice being issued. Should the records remain incomplete after that time, a seven-day pre-~~notice~~notification of ~~automatic~~administrative suspension will be issued ~~should the~~. Subsequent failure to complete outstanding records ~~remain incomplete. Failure to do so may~~shall result in ~~the~~an administrative suspension of all ~~hospital~~ Privileges except ~~for the~~that the Practitioner shall continue to provide ongoing care ~~of~~for patients already ~~in~~admitted to hospital and to fulfill medical department on-call obligations until the records are ~~completed~~complete.

~~(7)~~1.6.5.8 ~~Repeated failure to comply with the above requirements incurring~~After a Practitioner receives three automatic suspensions in any consecutive 12-month period, HAMAC may impose an automatic full suspension ~~on 3 occasions during any 12-month period may result in a suspension of~~ for up to 30 days ~~of all Privileges following a review by the HAMAC~~.

~~(F)~~1.6.6 Release of Health Records

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~~(1)~~1.6.6.1 All health ~~Records~~records maintained in VIHA-operated Facilities, paper-based ~~and~~or electronic, are ~~maintained by Island Health and are~~the property of VIHA. They shall not to be copied or removed from a VIHA Facility without the express written permission of the ~~-~~Health Records ~~Services, by request of the patient or~~Department, as ~~ordered by the courts.~~outlined in VIHA health-records policy.

~~(2)~~1.6.6.2 Community~~-~~based paper ~~Health Records~~health records may travel with the

patient, family or caregiver during the provision of care.

~~(3)~~1.6.6.3 Community~~-~~based Electronic Medical Records (EMR) may be electronically transferred to or accessed by a Practitioner currently involved in the care of that patient.

~~(4)~~1.6.6.4 ~~All~~A Practitioner may access all available ~~Island Health Health Records of any~~VIHA patient ~~shall be available~~health records as long as the Practitioner is MRP or has been asked by the MRP to ~~a Practitioner currently~~be clinically involved in ~~the care of~~ that ~~patient.~~patient's care.

1.6.6.5 Confidentiality of patient medical information is ~~paramount.~~of utmost importance. Practitioners ~~must respect and~~ shall adhere to ~~relevant Island Health~~:

(i) Federal or provincial legislation governing privacy and access to health records; and

~~(5)~~(ii) VIHA policies governing privacy and access to ~~paper-based Health Records and EHRs~~health records.

~~1.10~~1.7 MEDICAL STAFF MEMBERSHIP AND PRIVILEGES

1.7.1 Well~~-~~defined processes for application and maintenance of Medical Staff ~~Membership~~membership and Privileges within Facilities operated by ~~Island Health~~VIHA are ~~vital to good medical practice~~essential. Terms and criteria for appointment and membership are detailed in Article 3 of the Bylaws. Procedures for~~,~~ application, appointment and review are detailed in Articles 4 of the Bylaws. ~~Island Health~~VIHA supports ~~the assurance of~~ consistency and transparency in these processes~~, as outlined below~~.

~~(A)~~1.7.2 Procedure ~~for~~to Address Application ~~process~~Requests when ~~no vacancy is declared~~No Vacancy Is Declared

1.7.2.1 The procedures for application, appointment and review are set out in Article 4 of the ~~Medical Staff~~ Bylaws. ~~An individual~~

1.7.2.2 Individuals who ~~submits an~~submit unsolicited ~~letter~~letters of intent to apply for membership on the Medical Staff will be ~~contacted~~notified in writing ~~informing him/her~~ that ~~there is no vacancy.~~ no vacancy exists. A copy of each letter will be sent to the appropriate Department or Division Head for information.

1.7.2.3 An unsolicited letter of intent to apply for membership on the Medical Staff ~~is~~does not ~~considered a complete~~constitute an application in accordance with Article 4.1.3 of the Bylaws.

~~(B)~~1.7.3 Appointment to the Medical Staff

~~(1)~~1.7.3.1 Terms and criteria for Appointment to the Medical Staff, as well as procedures

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for application and review, are detailed in Articles 3 and 4 of the Bylaws.

1.7.3.2 ~~Appointment~~Appointments to the VIHA Medical Staff ~~shall be to Island~~ are Health ~~as an organization. The procedural~~ Authority wide.

1.7.3.3 Privileges ~~outlined within the appointment of each Medical Staff member shall describe and~~ define the scope and ~~limits~~location of ~~each~~a Practitioner's permit to practice in Facilities and Programs operated by VIHA. The Board may grant Privileges for more than one Facility or Program after considering the recommendation of HAMAC.

~~(2)~~1.7.3.4 Procedural Privileges are a permit to perform specific operations or procedures in Facilities and Programs ~~of Island Health.~~ operated by VIHA. Procedural privileges are:

(i) Assessed using specialty-specific British Columbia Provincial Privileging Dictionaries; and

(ii) Granted by the Board on the recommendation of HAMAC after an affirmative review of the training and competence of the Practitioner, the service needs of VIHA, and the available resources in a specific Facility or Program operated by VIHA.

1.7.3.5 The Department Head, or delegate, shall re-evaluate procedural privileges during the reappointment cycle to confirm the Practitioner's maintenance of competence, the ongoing service needs of VIHA, and the available resources in a specific Facility or Program operated by VIHA.

~~(3)~~1.7.3.6 Each ~~member of Medical Staff~~Practitioner will be assigned to a Primary Department. ~~Consideration~~HAMAC shall consider requests for ~~Appointment~~cross-appointment to ~~additional~~other Departments ~~will include, but not be limited to, the Practitioner's availability to participate in on-call rotations in additional Department(s).~~ on the advice of the Department Heads involved. Cross-appointments will be based on the Participant's ability to fulfill membership responsibilities in each Department to which the Practitioner is assigned.

~~(4)~~1.7.3.7 ~~Any~~An active or consulting staff member ~~of Medical Staff at a Facility or Program~~ may ~~be granted Medical Staff~~apply for Privileges ~~at~~in another Facility or Program operated by VIHA. Additional privileges may be granted by the Board ~~of Directors~~ following ~~appropriate~~ review ~~and~~of a recommendation by ~~the responsible Department Head and~~ HAMAC.

~~(5)~~1.7.3.8 The process for specialist ~~Practitioners to be recommended for Appointment~~recruitment to the ~~Provisional and Active~~Medical Staff is defined in VIHA Policy #3.1.2: Specialist Physician Recruitment ~~and~~. The appointment of a specialist requires ~~the~~ completion of ~~an impact analysis in accordance with~~a VIHA Impact Analysis and is governed by Article 3.1.5 of the Bylaws.

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~~(C) Procedural Privileges~~

~~(1) Procedural Privileges are granted in compliance with any applicable Provincial Privileging Dictionaries requirements. Procedural Privileges are granted at the time of initial Appointment to the Medical Staff based on the service needs of Island Health and the qualifications of the Practitioner.~~

~~(2) Maintenance of procedural Privileges will be reviewed by the Department Head on a periodic basis to confirm competence, ongoing expertise and continuing Program requirements.~~

~~(3) Application for additional procedural Privileges shall comply with Island Health credentialing process and include recommendation of the appropriate Department Head and respective medical Program leaders. Compliance with recommendations in the appropriate Provincial Privileging Dictionaries is required.~~

~~(D) Provincial Privileging Dictionaries~~

~~The Provincial Privileging Dictionaries are intended to bring consistent understanding and practice expectations for those requesting Privileges and for BC Health Authorities approving Privilege requests. They include diagnostic, procedural and non-procedural disciplines for Practitioners.~~

~~The Provincial Privileging Dictionaries are reviewed on a scheduled and recurring basis. Submissions for consideration to the Provincial Privileging Dictionaries are made to the provincial office and may be added to an Island Health Practitioners Privileges through the standard credentialing and privileging process in consultation with appropriate Department Heads who shall advise on the appropriate training of the applicant and demonstrated service need.~~

~~(E)~~1.7.4 Medical Staff Categories

1.7.4.1 Medical Staff categories are ~~defined~~identified in ~~the~~ Article 6 of the Bylaws~~.~~. The Rules provide further details about some of these categories. The Medical Staff categories are as follows:

- ~~provisional~~
- ~~active~~
- ~~associate~~
- ~~consulting~~
- ~~temporary~~

(i) ~~locum~~Provisional staff;
(ii) Active staff;
(iii) Associate staff;
(iv) Consulting staff;

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(v) Temporary staff;

~~•~~(vi) Locum tenens staff;

- ~~scientific~~Scientific and ~~research~~
- ~~honorary~~
- ~~dental~~
- ~~midwifery~~

(vii) ~~Island Health provides additional guidelines to inform the definition~~Research staff; and~~ use of the categories of Local Tenens and Temporary within these Rules.~~

(viii) Honourary staff.

~~(F)~~1.7.5 Locum Tenens Staff

1.7.5.1 Article 6.6 of the Bylaws defines the Locum Tenens Staff category and scope of practice. These Rules further define privilege activation or de-activation, maintenance of privileges and responsibilities for Locum Tenens Staff, as well as the role of Provisional, Active or Consulting Staff members seeking a locum tenens.

1.7.5.2 Members of the Locum Tenens Staff are appointed for a specified period of time, not to exceed twelve months, for the purpose of replacing a member of the Provisional, Active, or Consulting Staff during a period of absence.

1.7.5.3 Members of the Locum Tenens Staff may only replace an absent member of the Provisional, Active or Consulting Staff. "Absent" means being away from hospital or institution practice for a vacation, educational leave, illness or Board-approved leave of absence.

1.7.5.4 Members of the Locum Tenens Staff may cover on-call shifts only when they are providing locum coverage for an absent member for the specified period of the absence.

1.7.5.5 A request for Locum Tenens Staff for a period of less than 48 hours will only be approved in urgent circumstances.

1.7.5.6 While Locum Tenens Staff privileges may be granted for up to twelve months, each consecutive period of locum coverage must be approved in advance in order to activate privileges. When the approved period of coverage concludes, privileges are deactivated. For each subsequent locum-tenens coverage period a Provisional, Active or Consulting Staff member must submit a completed locum scheduling form to the Credentialing & Privileging Office confirming coverage dates, which then must be approved by the Division or Department Head prior to privilege re-activation.

1.7.5.7 A period of absence of more than 6 weeks is defined as a leave of absence (LOA) and must be recommended for approval by the Department Head, MPCC, and HAMAC to the Board (refer to Article 1.7.14 of these rules).

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1.7.5.8 Appointment to the ~~locum tenens~~Locum Tenens staff ~~provides~~conveys no preferential ~~access to Provisional~~status or ~~Active Staff or~~ privilege in seeking a future appointment to any ~~other~~ category of the Medical Staff

1.7.6 Application & Maintenance of Locum Privileges

1.7.6.1 A Provisional, Active or Consulting Staff member must advise the Credentialing & Privileging Office of the specific dates of any upcoming locum tenens requirement. The request must be approved by the Division or Department Head in advance.

1.7.6.2 Minimum lead times for Locum Tenens category privileges are:

(i) New Applicants: 6 weeks
(ii) Current Locum Tenens Staff requesting additional site privileges: 2-4 weeks.

1.7.6.3 In situations requiring urgent Locum Tenens appointment, the Chief Medical Officer (CMO), or designate, may grant interim privileges while the application is processed.

1.7.6.4 Upon approval by the Division or Department Head, applicants who have not previously held Island Health Medical Staff privileges will be provided an application package for new locum tenens privileges. The completed application package must be approved by the Division or Department Head, following which it will be forwarded to MPCC and HAMAC for a recommendation to the Board for approval.

~~(1)~~1.7.6.5 Performance appraisals will be completed annually or at ~~some later time~~the conclusion of the locum period, as determined by the Division or Department Head, and placed on the locum's personnel file.

1.7.7 ~~The member~~ Responsibilities of the Medical Staff ~~who will be replaced by a~~ Member Requesting a Locum Tenens

1.7.7.1 The Medical Staff member is responsible to notify the Credentialing & Privileging Office of an upcoming locum tenens arrangement by forwarding the completed locum scheduling form, indicating start and ~~the relevant Department Head are responsible~~end dates, within the required minimum lead time.

1.7.7.2 The Medical Staff member must be absent from the hospital or institution for ~~ensuring that the locum~~ the full period of locum coverage, except to permit orientation and patient handover.

~~(2)~~1.7.7.3 The Medical Staff member is responsible for the orientation of the locum-tenens ~~is suitably qualified. The Department Head or delegate shall familiarize the locum tenens with Facility and Program~~practitioner to the facility, including orientation to program policies and procedures ~~necessary for the medical care of patients~~required to support provision of care to patients. If the Medical Staff member is unavailable to fulfil these responsibilities, the Division or Department

Head shall assign the responsibility to another member of the Medical Staff.

~~(3) A member of Medical Staff on temporary leave, following consultation with the Division Head and/or Department Head, is responsible to determine what aspects of his/her practice the covering Practitioner is prepared and qualified to cover, and for making arrangements with other members of Medical Staff to attend to those aspects of the practice that the covering Practitioner will not cover.~~

~~(4) The locum tenens and Practitioner for whom the locum coverage is being provided may not work in Island Health Facilities during the same time period during which the locum tenens is privileged to cover for that Practitioner.~~

~~(5) The granting of a locum tenens appointment provides no preferential access to an active, provisional or other appointment at some later time. .~~

1.7.7.4 The Medical Staff member must confirm that the requirement for EHR competency has been attained by the locum-tenens practitioner. Locum tenens privileges will not be activated without confirmation of competency and/or completion of mandatory training.

1.7.7.5 The Medical Staff member is responsible for the completion of any health records the Locum Tenens practitioner fails to complete while providing locum-tenens coverage.

1.7.8 Responsibilities of Locum Tenens Practitioner

1.7.8.1 Locum Tenens privileges are granted to a specific physician for a defined period of time.

1.7.8.2 New Locum Tenens Staff must ensure EHR education modules are completed and competency has been achieved. Failure to do so may result in not receiving privileges in time to cover the desired locum.

1.7.8.3 Locum Tenens Staff members are responsible for the completion of all health records of patients for whom they have been caring. Failure to complete health records will result in a review of privileges by the Division or Department Head, which may impact the ability to obtain future Locum Tenens privileges.

1.7.8.4 Locum Tenens Staff may not assign their locum coverage to another Practitioner with Locum Tenens privileges.

1.7.8.5 The term of the locum ends automatically when the regular Medical Staff member returns to practice. Any requests to provide future locum tenens coverage must be sent to the Credentialing & Privileging Office for approval.

~~(G)~~1.7.9 Temporary Staff

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~~(1)~~1.7.9.1 The purpose of an Appointment to the ~~temporary staff category~~ Temporary Medical Staff is to fill a ~~temporary~~time-limited service need. Further details are outlined in Article 6.5 of the Bylaws.

1.7.9.2 ~~The granting of a temporary appointment provides~~Appointment to the Temporary staff conveys no preferential ~~access to an active, provisional or other~~ status or privilege in seeking a future appointment to any category of the Medical Staff.

~~(2)~~ Under normal circumstances, a Temporary staff appointment ~~at some later time.~~ must follow the policies and procedures used for any other

~~(H) Interim Appointment to Temporary~~ Medical Staff

1.7.9.3 ~~In cases where, under~~ appointment; in special or urgent circumstances, however, where temporary Medical Staff ~~Privileges are required, the CEO~~ may~~, in consultation with the Senior Medical Administrator,~~ need to be appointed quickly, the EVP & CMO, on the authority of the CEO, may grant ~~such appointments with specific conditions and for a designated~~Temporary Privileges for a specified purpose and period of time. ~~These appointments must~~Examples include:

(i) privileges required for organ retrieval;
(ii) demonstrating equipment or new procedures;
(iii) providing care during mass casualties; or
(iv) meeting a time-limited clinical need that temporarily overwhelms a Department's capacity to provide adequate coverage.

This appointment shall be ratified or terminated by the Board ~~of Directors~~ at its next scheduled meeting.

1.7.10 Interim Appointment

1.7.10.1 Interim Appointment is a term used by the VIHA HAMAC, MPCC and Medical and Academic Affairs Department to describe privileges granted to an applicant whose clinical services are required while an application is still proceeding through the approval process, which is outlined in Article 2.18 of these Rules.

~~(1)~~1.7.10.2 When circumstances require privileges to practice in a Facility or Program operated by VIHA before a final application can be reviewed by HAMAC and approved by the Board, the EVP & CMO may grant an Interim Appointment to the Medical Staff. The MPCC must have already reviewed the application to ensure completeness and the Department Head or delegate must have obtained favourable reports, including verbal reports, from the referees identified in Article 4 of the Bylaws.

1.7.10.3 The ~~nature of the interim Appointment with Temporary Privileges shall be~~

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~~clearly~~ Interim Appointment shall remain in effect until the Board has an opportunity to review HAMAC's recommendation and reach a decision, or for up to three (3) months, whichever period is shorter.

1.7.10.4 An Interim Appointment may be renewed once if the EVP &CMO is satisfied that extenuating circumstances justify the renewal.

~~(2)~~1.7.10.5 The purpose of the Interim Appointment shall be indicated clearly in writing to the Practitioner and~~, where~~ the applicable~~, indicated as such on all notices and correspondence regarding an applicant's Appointment.~~ Department Head.

1.7.10.6 ~~The granting of an interim~~Interim Appointments permit applicants to practice for the defined term in the Medical Staff category to which they have applied.

~~(3)~~1.7.10.7 An Interim Appointment ~~with Temporary Privileges provides the temporary member~~conveys no preferential ~~access~~status or privilege in seeking a future appointment to ~~an Appointment to categories~~any category of the Medical Staff ~~at a later time.~~ .

~~(4)~~1.7.10.8 The ~~interim~~application of a Practitioner granted an Interim Appointment ~~with Temporary Privileges~~ must be reviewed at the next HAMAC meeting and ~~forward~~forwarded to the Board ~~of Directors~~ for decision at ~~its subsequent~~the Board's next scheduled meeting.

~~(5)~~1.7.10.9 In the event that the Board ~~of Directors~~ does not approve the ~~interim~~appointment of an applicant with an Interim Appointment ~~with Temporary Privileges~~, the applicant shall cease all clinical activity in ~~any Island Health~~ the Facilities and Programs operated by VIHA and immediately transfer the ongoing care of any ~~patient under his/her care~~admitted patients to an appropriate member of Medical Staff.

1.7.11 Clinical Fellows

1.7.11.1 Appointments: Clinical Fellows are physicians who have applied to and been accepted by VIHA for further training in a clinical discipline. They must have medical liability insurance acceptable to VIHA, be licensed by the College of Physicians & Surgeons of British Columbia and be registered with the Faculty of Medicine at the University of British Columbia. Clinical Fellows shall be accepted only if supported by the appropriate Department Head, recommended by HAMAC and approved by the Board. This process is congruent with the requirements for an appointment to the Medical Staff.

1.7.11.2 Scope of Practice: Clinical Fellows may attend patients under the supervision of a member of the Active, Provisional, Consulting or Locum Medical Staff of the department responsible for supervision of their work in Facilities operated by VIHA. They may carry out such duties as are assigned to them by the Head of the

Department or delegate to whom they have been assigned. They may not admit patients. They may not vote at Medical Staff or Department meetings.

1.7.12 Clinical Trainees

1.7.12.1 Appointments: Clinical Trainees are those physicians, dentists, midwives or nurse practitioners who have applied to and been accepted by VIHA for further clinical training. They must have adequate liability insurance and be licensed by the College of Physicians and Surgeons of British Columbia, the College of Dentistry of British Columbia, the College of Midwives of British Columbia, or the College of Registered Nurses of British Columbia. Clinical Trainees shall be accepted only if supported by the appropriate Department Head, recommended by the HAMAC and approved by the Board. This process is congruent with the requirements for an appointment to the Medical Staff.

1.7.12.2 Scope of Practice: Clinical Trainees may attend patients under the supervision of a member of the Active or Provisional Medical Staff of the department responsible for supervision of their work. They may carry out such duties as are assigned to them by the Department Head or delegate to whom they have been assigned. They may not admit patients. They may not vote at Medical Staff or Department meetings.

1.7.13 Students

1.7.13.1 Medical, Midwifery, Dentistry and Nurse Practitioner Students on Required Rotations

(i) All Medical, Midwifery, Dentistry and Nurse Practitioner Students working within a hospital, program or department must be registered through the applicable clinical Faculty at the University of British Columbia, be attending a WHO/FAIMER-recognized medical school, or be attending a school with which VIHA has an affiliation agreement.

(ii) They must hold a valid educational license from their professional College in British Columbia.

(iii) Students may attend patients under the direct supervision of a member of the Active, Provisional, Consulting or Locum Medical Staff, Resident staff or a Clinical Fellow in the department responsible for their training program.

(iv) Orders written by students must have been discussed with the supervisor prior to being implemented and must be countersigned at the earliest opportunity, within 24 hours at the latest.

(v) Students shall not sign certificates of death.

(vi) Students shall not discharge patients without appropriate review by a qualified member of the medical staff.

(vii) Although not members of the Medical Staff, students must abide by the policies and guidelines of VIHA and its Medical Staff.

1.7.13.2 Medical, Midwifery, Dentistry and Nurse Practitioner Students on Elective Clinical Rotations

(i) Medical, Midwifery, Dentistry and Nurse Practitioner Students, Residents and Clinical Fellows from the University of British Columbia (UBC) and from medical schools outside of British Columbia may be authorized by the CMO to do elective clinical rotations at facilities and programs of VIHA.

(ii) All electives must be approved and registered through the applicable clinical Faculty at the University of British Columbia and be licensed by the applicable College in British Columbia. The scope of practice and requirements for supervision shall be the same as for those on required rotations.

~~(I)~~1.7.14 Leave of Absence

1.7.14.1 ~~Any~~ An absence from Medical Staff practice for a period ~~exceeding~~ between six (6) weeks and ~~up to~~ 12 months ~~shall be~~is considered a Leave of Absence (LOA~~) and~~). Each LOA requires approval ~~of~~by the Board ~~of Directors~~ as ~~per~~outlined in Article 4.7.2 of the Bylaws~~.~~

1.7.14.2 ~~Island Health policy 3.3.1P~~.

1.7.14.3 Where the LOA was granted for medical reasons or because a Practitioner's registration status has been changed to Temporarily Inactive by the applicable College, supporting documentation must be received from an independent medical practitioner acceptable to the EVP & CMO and from the applicable College that the Practitioner is fit to return to work. The documentation shall include what restrictions, if any, apply to the resumption of independent practice.

1.7.14.4 VIHA Policy # 3.3.1P provides additional and guidance on processes related to LOA.

~~(J)~~1.7.15 Reappointment ~~of Privileges~~to the Medical Staff

~~1.5.1.1~~1.7.15.1 The process for reappointment is set out in Article 4.4 of the Bylaws.

1.7.15.2 ~~Island Health policy 3.3.2P~~VIHA Policy #3.3.2P provides additional information and guidance on processes related to Reappointment.

~~(K) Suspension of Privileges~~

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~~Suspension of privileges is outlined in Article XX Health Records, and Article XXX Discipline of these Medical Staff Rules.~~

~~(L)~~1.7.16 Maintenance of Current Practitioner Information

~~(1)~~1.7.16.1 ~~Members of Medical Staff are required to~~ Practitioners shall inform ~~Island Health~~VIHA of any changes that ~~would~~may affect their ability to practice ~~medicine for which they are privileged to practice while a member of~~ as members of the Medical Staff, including but not limited to changes to licensure, professional liability insurance coverage, health, qualifications, professional misconduct and immigration status.

~~(2)~~1.7.16.2 ~~Members of Medical Staff will~~Practitioners shall keep ~~Island Health~~the VIHA Medical and Academic Affairs Department updated on any changes to their contact information, including home, office or practice location addresses, email addresses and telephone number(s).

~~(M)~~1.7.17 In-Depth Practitioner Reviews

~~(1)~~1.7.17.1 Periodic reviews are meant to be a collaborative, positive approach to professional growth and development. The ultimate goal with periodic reviews is to provide Practitioners with objective data that will assist them in continually improving their clinical and professional skills, in addition to recognizing excellence and in turn providing high quality, safe patient care.

~~(2)~~ In-depth reviews are primarily for the review process when considering moving a Practitioner from provisional to active staff category, or for locum tenens completing the first 6 to 12 months of service~~, and is~~. Theyare intended to be used for periodic reviews of all Practitioners on a three year basis~~.~~

~~(3)~~1.7.17.2 ~~,~~ The process for reviews is set out in Article 4.5 of the Bylaws.

~~(N)~~1.7.17.3 The recommended format of the periodic performance review is based on the CanMEDS Framework and will include a self-assessment to be completed and brought ~~along~~ to the review meeting with the Department Head or delegate. The Department Head may seek input from ~~a chart~~sources including a health record review, outcome measures, incident reports or complaints, multi-sourced feedback from team members, and interviews with ~~the~~ appropriate senior staff.

~~(1)~~1.7.17.4 The practice and performance review may be completed by:

~~(a)~~(i) A Department Head~~;~~
~~(b)~~(ii) A Division Head~~;~~
~~(c)~~(iii) The Chief of Staff of the local Facility~~;~~, or
~~(d)~~(iv) An external reviewer, approved by the HAMAC on the recommendation of the Department Head, Executive Medical Director or ~~Chief Medical Officer~~EMD & CMO.

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~~(2)~~1.7.17.5 The Department Head or delegate ~~will~~shall discuss the results and recommendations of the in-depth review with the Medical Staff member, who will be provided a copy of the review findings and recommendations. A member's concerns with the review should be addressed through the CMO and ultimately HAMAC as necessary.

~~(3) A member's concerns with the review should be addressed through the Senior Medical Administrator and ultimately HAMAC as necessary.~~

~~(4)~~1.7.17.6 The MPCC, as defined in Article 2.5 ~~(C) (1),~~.9.22, shall support the process for performance-reviews and report any concerns regarding consistency, validity and procedural fairness to HAMAC.

~~(O)~~1.7.18 Mid-Term Changes to Privileges

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~~(1)~~1.7.18.1 A mid-term request for additional Privileges or extension of Privileges will be considered according to the process set out in Article 4.3 of the Bylaws.

~~(2)~~1.7.18.2 In the event that a member wishes to resign from the Medical Staff, change membership status, or substantially reduce the scope of his/her practice within the Facilities~~/~~ or Programs operated by Island Health, the member must provide 60 days prior written notice to Island Health unless waived by the Board.

~~1.11 QUALITY SPECTRUM – PENDING THIS SECTION IS WITH A. HARRISON FOR REVIEW AND INPUT. SHE RETURNS FROM HOLIDAY JULY 26.~~

~~In order to ensure quality, Practitioners maintain and enhance their skills to work in the best interests of the patients they serve. Island Health uses Accreditation Canada Quality Standards to help define quality.~~

~~(A) Individual Quality~~

~~The CanMEDs framework competencies as outlined in Article 1.3 link quality improvement and patient safety. These competencies may be used as a benchmark to assure quality and quality improvement.~~

~~(B) Systems Quality~~

~~Island Health's quality framework is based on the Institute for Healthcare Improvement (IHI Triple Aim) as outlined in Article 1.1.~~

~~Practitioners are essential participants in all aspects of systems quality and will participate in:~~

~~(1) Standard setting, which takes place at the Program level;~~

~~(2) Implementation and measurement of quality initiatives which occur at the local level; and~~

~~(3) Supporting and educating others in quality improvement and safety~~

~~(C) Supporting Learners in Quality, Safety and Improvement~~

~~Medical students and residents are not members of the Medical Staff as defined in the Bylaws, but Residents, Fellows and Trainees are encouraged to participate in Quality Improvement activity provided there is adequate supervision by their Practitioner.~~

~~Article 2 –~~ 2 Organization of the Medical Staff

2.1 ~~Role of~~ Medical and Academic Affairs (MAA)

2.1.1.1 Medical and Academic Affairs is the administrative department that supports the Medical Staff ~~organization and organizational medical leaders in the delivery of effective, efficient and consistent quality processes which support recruitment, credentialing, privileging, onboarding and orientation, performance process, governance, quality improvement, continuing professional development, contracting and remuneration of members of the Medical Staff of Island Health.~~Organization and its leaders by developing and implementing policies and procedures that support:

(i) Effective recruitment;
(ii) Credentialing and privileging;
(iii) Onboarding and orientation;
(iv) Quality and performance improvement;
(v) Medical Staff governance;
(vi) Contract management and remuneration and;
(vii) Continuing professional development
(viii) Medical staff wellness and resilience

2.1.2 Chief of Staff

~~2.2~~2.1.2.1 The Chief of Staff (CoS) is a physician leader appointed to a Facility rather than to a Department ~~Structure~~or Program.

2.1.2.2 The CoS is the on-site Deputy of the CMO.

2.1.2.3 The CoS may act as the Chair of the Local Medical Advisory Committee (LMAC). In this role the CoS reports to the Chair of HAMAC.

2.1.2.4 Each site will not necessarily have a unique Chief of Staff.

2.1.2.5 The CoS collaborates directly with VIHA Department Heads and Division Heads to:

(i) Monitor and enhance medical governance within the Facility.

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(ii) Act as the liaison for all Department Heads at the Facility
(iii) Exercise emergency executive function for a Department Head as required.

2.1.2.6 The CoS:

(i) Co-develops and co-implements plans to engage and support Facility Practitioners and staff through change;
(ii) Engages administrative and medical leaders to anticipate, assess, monitor and prioritize Facility needs within the available resources; and
(iii) Assists in the management of Practitioner professional behaviour and discipline in the Facility, in collaboration with the applicable Division or Department Head, LMAC, HAMAC, and the CMO.

2.1.2.7 The CoS also may maintain a separate operational role as the Facility's Site Medical Director.

2.2 Organization of the Medical Staff

2.2.1 VIHA maintains a medical leadership structure in support of governance and clinical operations of the Health Authority. A description of the current structure can be found (link).

~~(1)~~2.2.2 In accordance with Article 7 of the Bylaws, the Board ~~of Directors~~, upon the advice of the HAMAC, shall organize the Medical Staff into Departments, Divisions and Sections ~~as warranted by the professional resources of the Medical Staff and Island Health's resource availability~~.

~~(2)~~2.2.3 All members of the Medical Staff ~~will~~shall belong to at least one Department and maintain privileges in at least one site~~. Members may belong to more than one Department and have Privileges at more than one site depending upon local need, resources and interest. Privileges will be site specific.~~, as outlined in Article 2.9.15 of these Rules.

~~(A)~~2.2.4 Departments

~~(1)~~2.2.4.1 The Medical Staff Departments in ~~Island Health~~VIHA shall be:

(i) Pathology and Laboratory ~~&~~ Medicine;
~~(a)~~(ii) Imaging Medicine;
~~(b)~~(iii) Medicine;
~~(c)~~(iv) Psychiatry;
~~(d)~~(v) Maternity Care & Pediatrics;
~~(e)~~(vi) Primary Care;
~~(f)~~(vii) Surgery;

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~~(g)~~(viii) ~~Anaesthesiology~~Anesthesiology, Pain & Perioperative Medicine; and

~~(h)~~(ix) Emergency & Critical Care Medicine.

~~(2)~~2.2.4.2 Departments are Health-Authority wide structures~~; activity~~. Activity within Departments is specific to each site.

~~(3)~~2.2.4.3 All Departments will not necessarily ~~be constituted~~have members or Division Heads at every site ~~and will reflect both~~, reflecting local ~~need~~requirements and resource availability.

2.2.5 Divisions

2.2.5.1 Departments ~~will~~may be further organized into Divisions ~~of clearly defined specialty interest and where required,~~.

~~(4)~~ At tertiary-care Facilities, Divisions may be organized into Sections ~~of defined sub-specialty interest.~~

~~(B)~~2.2.5.2 ~~Divisions~~

~~(1)~~2.2.5.3 Divisions are clinically ~~-~~defined specialty ~~professional~~ groups ~~of Practitioners~~ within a ~~given~~ Department.

~~(2)~~2.2.5.4 ~~All~~ Divisions will not necessarily ~~be constituted~~have members at every site ~~and will reflect both~~, reflecting local ~~need~~requirements and resource availability.

~~(3)~~2.2.5.5 ~~The~~ Two Divisions, the Division of Public Health ~~and~~& Preventative Medicine ~~will be constituted as a single~~ and the Division of Nurse Practitioners, are VIHA-wide stand~~-~~alone~~, Island-wide Division~~ Divisions, with voting membership on the HAMAC.

~~(C)~~2.2.6 Sections

~~(1)~~2.2.6.1 Sections are clinically ~~-~~defined sub-specialty ~~professional~~ groups of Practitioners within a ~~given~~ Division ~~or Department.~~.

~~(2)~~2.2.6.2 All Sections will not necessarily ~~be constituted~~have members at every site ~~and will reflect~~, which reflects both local need and resource availability.

~~(D) Chief of Staff~~

~~(1) The Chief of Staff is a Facility or site-based role acting as on-site representative of every Department Head.~~

~~(2) All sites will not necessarily have a chief of staff.~~

~~(E)~~2.2.7 Meetings

~~(1)~~2.2.7.1 Each Department shall meet ~~a minimum of~~ two times per year, and at the call of the Department Head to conduct its administrative affairs as outlined in Article 7.2

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of the Bylaws.

~~(2)~~2.2.7.2 ~~The~~ Department ~~Head will~~Heads shall meet with their Division Heads at a minimum of ~~three~~four (4) times per year.

~~(3)~~2.2.7.3 Each Division shall meet a minimum of five (5) times per year at the call of the Division Head to conduct its administrative affairs as they pertain to its geographical mandate.

~~(4)~~2.2.7.4 Each Section shall meet at the call of the Section Head a minimum of three (3) times per year.

~~(5)~~2.2.7.5 Meetings may be in person, by video or teleconference.

~~(6)~~2.2.7.6 Active Members of Medical Staff are ~~expected~~required to ~~be present for~~attend at least 70% of primary departmental/divisional meetings.

~~(7)~~2.2.7.7 Departmental Leadership meetings shall follow the meeting governance and operations processes as outlined in Article 2.5 (A) of these Rules.

2.3 ~~ROLE OF~~ Medical Staff Departmental Leadership

2.3.1 ~~Within a health authority~~In VIHA, the Bylaws define and the Rules amplify clarify the roles and responsibilities of ~~practitioners~~Practitioners and their leaders as Department, Division and Section Heads. These leaders provide ~~assurances~~assurance of public safety by ensuring each practitioner in a department is currently qualified and privileged to provide care and that the care provided is in the patient's best ~~interests~~interest.

2.3.2 ~~The~~Physician-leadership oversight roles are articulated in ~~seven key areas as outlined below:~~ this Article of the Rules and address:

~~(1)~~(i) Standards of Care & documentation;
~~(2)~~(ii) Recruitment, resource planning;
~~(3)~~(iii) Privileging;
~~(4)~~(iv) Performance monitoring & improvement;
~~(5)~~(v) Education and research;
~~(6)~~(vi) Professional Competence and Behaviour;
~~(7)~~(vii) Individual Provider Quality; and
(viii) Medical staff wellness and resilience

2.3.3 Department Heads

~~(B)~~2.3.3.1 The responsibilities of the Department Head are outlined in Article 7.2 of the Bylaws.

2.3.3.2 The Department Head ~~is an island~~has VIHA-wide ~~role overseeing the self-~~ responsibilities.

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2.3.3.3 The Department Head shall be an Active-Staff member of the applicable Department who provides governance ~~of its'~~ and leadership to Department members ~~who practice in Island Health Facilities~~ in accordance with ~~Island Health's~~the Bylaws and Rules.

2.3.3.4 The Department Head shall be selected on the basis of qualifications, training, leadership experience and demonstrated clinical, teaching and administrative ability.

2.3.3.5 Where a Department Head vacancy exists, a search committee shall be struck.

2.3.3.6 The search committee shall act in an advisory role to the CMO.

2.3.3.7 Following the search process, the Department Head shall be appointed by the Board upon the recommendation of the CMO and HAMAC after considering the advice of the search committee. Members of the HAMAC and the applicable Department will be represented on the committee.

2.3.3.8 The Department Head reports to the ~~Chief Medical Officer~~CMO.

2.3.3.9 The term of appointment for a Department Head shall be five (5) years, renewable once.

2.3.3.10 The Department Head or delegate attends all meetings of the HAMAC as a voting member and participates on HAMAC sub-committees at the request of the HAMAC Chair.

2.3.3.11 The Department Head shall identify an Assistant Head to assume the responsibilities of the role in the Department ~~Head are~~Head's absence.

~~(1)~~2.3.3.12 In addition to those duties outlined in Article 7.2 of the Bylaws~~.~~, the Department Head shall:

~~Additional expectations of Department Heads include:~~

~~(a)~~(i) ~~Practice standards: Guide implementation~~Lead the development of procedures to create and routinely monitor medical practice standards, including the use of standards ~~in~~for practice assessment~~.~~;

~~(b)~~(ii) ~~Medical resource planning and recruitment: Collaboratively monitors and anticipates Departmental~~ Monitor and anticipate Department workforce needs, and ~~works~~collaborate with Medical and Academic Affairs to help address ~~identified~~those needs ~~and fulfill~~ those needs through effective recruitment~~.~~;

(iii) ~~Research and education: Guide~~Lead the implementation of procedures to support Department members to ~~conduct research and to provide~~ participate in medical education~~. Ensures Department member workload accommodates~~ and research;

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~~(c)~~(iv) Ensure the Department workforce plan provides sufficient staff to meet clinical requirements while accommodating medical-education and research ~~and medical education~~ activities~~.~~;

~~(d)~~(v) ~~Individual Practitioner Quality (IPQ):~~ Monitor and facilitate ~~continuous improvement of Individual Practitioner Quality.~~improved quality of practice for individual Department members;

(vi) ~~A~~Collaborate in the development of robust Practitioner recruitment.

(vii) Attend to Credentialing and Privileging requirements;

(viii) Implement a process for periodic in-depth Practitioner review;

(ix) Oversee Continuing Professional Development (CPD), including implementation of an annual CPD plan for the Department; and

(x) Collaborate with the Enhanced Medical Staff Support (EMSS) team to support the development and maintenance of positive Departmental relationships and working environments.

2.3.3.13 The CMO shall be responsible for conducting a regular performance review of each Department Head ~~will select an~~ .

2.3.3.14 In the final year of a Department Head's term, a Committee shall be struck to review and provide recommendations regarding future appointment.

2.3.3.15 The Board of Directors, on the recommendation of the CMO or in its sole discretion, may suspend or terminate the appointment of a Department Head. Prior to such suspension or termination, reasonable notice shall be given to the Department Head, the CMO and the HAMAC.

~~(e)~~2.3.3.16 If a Department Head resigns or is removed, the Assistant Department Head ~~who will~~shall assume ~~all~~ the responsibilities ~~in~~ of the Department Head until a successor has been appointed. In the absence of ~~the Department Head.~~an Assistant Department Head, the CMO may assume or delegate this role after consultation with the HAMAC Chair.

2.3.3.17 If a Department Head selection committee fails to identify or recommend a suitable candidate for Department Head, the Board shall delegate the responsibilities of the Department Head to the CMO or another Member recommended by the CMO, on an interim basis.

~~(f)~~ Division Head~~A Department Head will be a voting member of the HAMAC and attend meetings and will participate on other committees as defined within these Rules or as appropriate.~~

2.3.4

2.3.4.1 The responsibilities of the Division Head are outlined in Article 7.2 of the Bylaws.

2.3.4.2 The Division Head generally fulfils the same role for the Division as the Department Head does for the Department.

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~~(C)~~2.3.4.3 Division Heads have cross-Facility responsibilities.

2.3.4.4 The Division Head ~~is a subject-matter expert~~shall be an Active Staff member of the Division who provides governance and leadership to ~~Division~~Department members in accordance with the Bylaws and Rules

2.3.4.5 The Division Head shall be selected on the basis of qualifications, training, leadership experience and demonstrated clinical, teaching and administrative ability.

2.3.4.6 The Division Head is appointed by and reports to the applicable Department Head after consultation with Division members.

2.3.4.7 The Division Head collaborates with the Department Head to ensure the provision of high-quality ~~medical~~clinical services ~~at the site~~by Practitioners within the ~~scope of the~~ Division. ~~The Division Head reports to the Department Head.~~

The ~~main responsibilities of the~~ Division Head ~~are:~~

~~(a)~~2.3.4.8 ~~Medical workforce planning: Collaboratively monitor and anticipates~~ assists the Department Head by completing QPID activities for the Division ~~workforce needs, and works with the Department Head and Medical and Academic Affairs to address identified needs and fulfill those needs through recruitment~~.

~~(b) Practice standards: Leads development and routine monitoring of medical practice standards.~~

~~(c) Research and education: Supports~~The Division ~~members to conduct research and to provide medical education.~~

~~(d) Individual Practitioner Quality (IPQ): Facilitates continuous improvement of IPQ by participating in:~~

~~(i) Credentialing and Privileging activities including periodic in-depth reviews of Division members.~~

~~(ii) Continuing Professional Development (CPD) activities, including implementing the annual Departmental CPD plan for Division members.~~

~~(iii) Practitioner performance improvement activities in collaboration with Enhanced Medical Staff Support (EMSS) team.~~

~~(e)~~2.3.4.9 Head attends and participates ~~Attendance and participation~~ on committees ~~as defined within these Rules or as appropriate~~in consultation with the Department Head.

2.3.4.10 The term of appointment for a Division Head shall be five (5) years, renewable once.

~~(D)~~2.3.5 Section Head

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~~The Section Head is a sub-specialty subject-matter expert who advises the Division Head on Section matters. The Section Head reports to the Division Head.~~

2.3.5.1 ~~The main~~ The responsibilities of the Section Head ~~position~~ are~~:~~ outlined in Article 7.2 of the Bylaws.

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~~(a) Medical Workforce Planning: Collaboratively monitor and anticipate~~ The Section ~~workforce needs, and works with~~Head generally fulfils the ~~Division Head to address identified needs.~~

~~(b) Practice Standards: Collaborates with Division Head to develop medical practice standards for subspecialty.~~

~~(c) Research and Education: Encourages Section members to conduct research and to provide medical education.~~

~~(E) Chief of Staff~~

2.3.5.2 ~~The Chief of Staff is a leadership position organized by site rather than by discipline. This~~same role ~~links directly with Department Heads and Division Heads to monitor and enhance medical governance within~~ for the ~~site. The Chief of Staff is also has a separate operational role~~ Section as the ~~operational structure's Site Medical Director. The Chief of Staff role reports to~~Division Head does for the ~~Department Head~~Division.

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2.3.5.3 ~~The main~~ Section Heads may have cross-Facility responsibilities ~~of the Chief of Staff role: ~~.

~~(a) Acting as the liaison for all Department Heads at the site/Facility and exercising emergency executive function for a Department Head as required.~~

~~(b) Change Management: Co-develops and implements change management plans to engage and support site Practitioners and staff through change.~~

~~(c) Planning: Assesses, monitors and anticipates site resource needs and works with Medical and Administrative leaders to prioritize these needs within available resources.~~

~~(d) Professionalism: initiates and oversees initial issues regarding Practitioner discipline in the site/Facility.~~

~~(F) Appointment, Selection Process and Review of Departmental Leadership~~

~~(1) Department Heads~~

2.3.5.4 ~~Each Department Head shall be a~~ The Section Head is an Active Staff member of the ~~active staff of that Department and shall be appointed by the Board of Directors.~~

~~Department Heads~~ Section who provides governance and leadership to Section members in accordance with the Bylaws and Rules.

~~(a)~~2.3.5.5 The Section Head shall be selected on the basis of qualifications ~~of~~, training, leadership experience, and demonstrated ~~ability in~~ clinical ~~skills~~, teaching and administrative ~~activities~~ability.

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~~(b) The term of appointment for a Department Head shall not be less than one year and shall not exceed three years. The Board of Directors may reappoint a Department Head for up to two consecutive additional terms on the recommendation of the HAMAC.~~

~~(c) The Senior Medical Administrator shall be responsible for conducting an annual performance review of each Department Head. In the final term of appointment, the Search Committee shall be convened to review and provide recommendation regarding the status of appointment.~~

~~(d) Where Department Head vacancy exists, that is to be filled by a regular appointment by the Board of Directors, a Search Committee shall be convened in accordance with the Rules.~~

~~(e) The Board of Directors may, on the recommendation of the HAMAC, or in its sole discretion, suspend or terminate the appointment of any Department Head. Prior to such suspension or termination, reasonable notice shall be given to such Department Head and to the HAMAC.~~

~~(f) In the absence of a Department Head, the Assistant Department Head will assume the responsibilities of the Department Head until successful selection has been made. In the absence of an Assistant Department Head, the Senior Medical Administrator may assume or delegate this function in consultation with the HAMAC Chair.~~

~~(g) In the event of failure of the Department Head selection process to identify and recommend a candidate for Department Head suitable to the Board of Directors for appointment, the Board of Directors shall delegate the responsibilities of the Department Head to the Senior Medical Administrator, or another Member recommended by the Senior Medical Administrator, on an interim basis.~~

~~(2) Division Heads~~

~~(a)~~2.3.5.6 ~~Division Heads shall be appointed by the Department Head~~ The Section Head shall be appointed by the Division Head after consultation with ~~Division~~Section members.

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~~(b) Each~~ The Section Head collaborates with the Division Head ~~shall be a member~~to ensure the provision of ~~the active staff and selected on the basis of qualifications of training, experience and demonstrated ability in~~high quality clinical~~, teaching and administrative abilities.~~

~~(c) The term of appointment for a~~ services~~Division Head shall be up to five years. The Department Head may reappoint a Division Head for one additional term.~~

~~(3) Section Heads~~

2.3.5.7 ~~Section Heads shall be appointed~~ by Practitioners within the ~~Division Head after consultation with~~ Section.

~~(a)~~ The accountabilities of the Section ~~members.~~

~~(b)~~2.3.5.8 ~~Each~~ Head are similar to those of the Division Head, but at the Section ~~Head shall be a member of the active staff and selected on the basis of qualifications of training, experience and demonstrated ability in clinical, teaching and administrative abilities~~level. **Formatted:** Heading 4

2.3.5.9 The ~~term of appointment for a~~ Section Head ~~shall be up to five years. The~~ assists the Division Head ~~may reappoint a~~ by completing QPID activities for the Division.

~~(c)~~ The Section Head ~~for one additional term.~~

~~(4) Chief of Staff:~~

~~(a)~~2.3.5.10 ~~The Chief of Staff shall be appointed by the Senior Medical Administrator~~attends and participates on committees in consultation with ~~and endorsement by~~ the ~~HAMAC~~Division Head. **Formatted:** Heading 4

2.3.5.11 The term of appointment for ~~the Chief of Staff will reside~~a Section Head shall five (5) years, renewable once.

2.3.6 On-call coverage for admitted patients

~~(b)~~ Practitioners with ~~the term of appointment for the Site Medical Director of a given Facility.~~

~~(G) On Call Roster~~

2.3.6.1 ~~A Practitioner granted admitting~~MRP Privileges to ~~a Facility in Island Health has~~practice in Facilities operated by VIHA have a professional obligation to be continuously available ~~at all times~~ to meet the medical needs of ~~his/her patient.~~ their admitted patients.

2.3.6.2 Groups of Practitioners~~, usually those~~ with a similar scope of practice ~~content,~~ may join together in call-groups to ~~alleviate~~share the ~~burden~~requirements of ~~this~~ **Formatted:** Heading 4

~~obligation by agreeing~~after-hours care. These Practitioners shall create an on-call rota to ~~take responsibility~~ensure 24-hour coverage for the group's ~~collective~~ in-patients in a manner ~~which satisfies~~acceptable to the group~~. This is described as being "on-call".~~ and the CMO.

~~(1)~~ On-call Responsibilities ~~to being on-call:~~

2.3.6.3 ~~Within a~~ for Emergency-Department (ED) patients or admitted patients who require urgent consultation from non-MRP Practitioners

2.3.6.4 Unless specifically excluded by the HAMAC, all Departments, Divisions and ~~under the guidance~~Sections are required to provide continuous on-call coverage to manage:

(i) ED patients who require urgent consultation or in-patient admission; and

(ii) Patients already admitted to hospital whose condition necessitates urgent intervention or consultation by a Practitioner other than the MRP.

2.3.6.5 Unless specifically excluded by the HAMAC on advice from the applicable Department Head, all Department members are required to participate equitably in fulfilling the on-call responsibilities of the Department~~ Head, the Division~~.

2.3.6.6 Facility-based resources shall be distributed preferentially among Practitioners who provide equitable on-call coverage or other essential services required by VIHA. This applies most specifically to Facility resources used by the Practitioner to generate clinical income.

~~(a)~~2.3.6.7 The Department Head ~~will assemble~~or delegate shall develop a list of Practitioners belonging to each call group within the ~~Division to be identified as being~~Department, and maintain an on-call ~~group. With the exception of the Division of Public Health and Preventative Medicine, all members of the Division are required to assemble themselves into groups willing to take responsibility for their group members' patients~~rota that shall be provided in advance to the VIHA switchboard.

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~~(b)~~2.3.6.8 ~~Where~~Wherever possible, ~~an on~~-call group members should share equivalent ~~qualification~~qualifications to ensure consistency ~~and continuity~~ of patient care ~~to the patient~~.

~~(c)~~2.3.6.9 Where community~~-~~ size ~~and/~~or Practitioner ~~complement require~~numbers necessitates a ~~blended skillset within an on-~~call group whose Practitioners have different skillsets, the call-group~~, the~~ members must ~~ensure an internal communication~~ establish a group on-call strategy to ~~meet the care~~ensure all medical needs ~~required for~~of the patient are met.

~~(d)~~2.3.6.10 Where call-group members ~~of a common clinical specialty~~ practice in different

communities, ~~a common on-call rota~~ the members may ~~be established by the members upon~~ establish a cross-community on-call rota, provided a clinical service-delivery model is established to ensure patients have local access to the on-call member as required. A cross-community on-call rota requires Department-Head approval ~~of the Department Head~~ after consultation with the ~~necessary~~applicable geographical Division Head(s~~) provided a clinical service delivery model is established to ensure that patients have local access to the on-call member as necessary.~~).

~~(c) In the case of members of Medical Staff acting as service providers under contract members will be on-call in accordance with the requirements of their service contract in order to achieve continuous service provision as necessary. The roster of on-call services will be provided in a timely manner by the service contractor and approved by the respective Department / Divisional Head.~~

2.3.6.11 The method of Practitioner compensation, whether through fee-for-service, alternate payment contract or sessional payment, has no bearing on the individual or collective requirement to provide continuous on-call coverage.

2.3.6.12 The availability, or lack thereof, of a Medical On-Call Availability Program (MOCAP) contract has no bearing on the individual or collective requirement to provide continuous on-call coverage.

~~(2)~~2.3.7 On-call scheduling~~:~~

~~(a)~~2.3.7.1 The ~~creation~~establishment of an on-call schedule is ~~a~~ mandatory ~~requirement of a given on~~ for each call group and must ~~meet the following criteria~~:

(i) ~~It must provide an~~Provide a Practitioner available ~~Practitioner~~ to assess and treat the patient(s) ~~24/7/365.~~at all times;

(ii) ~~It must be~~Be maintained in up-to-date fashion at all times~~.~~;

(iii) ~~It must identify~~Identify the Practitioner by name ~~with guaranteed~~, including up-to-date expedited contact information ~~for the hours of on-call service.~~;

(iv) ~~It must identify~~Identify the Practitioner responsible for maintaining the on-call list, ~~complete with~~including contact information~~.~~;

(v) ~~It must be~~Be made available ~~to Island Health~~ in a manner ~~and at a~~, time and ~~in a~~ format acceptable to ~~Island Health~~VIHA in order to distribute ~~the on-call schedule~~ it to necessary recipients~~.~~; and

(vi) ~~It must be~~Be submitted by the ~~on-call group~~ Department Head or delegate at least 28 days ~~ahead of~~prior to the ~~current~~ date~~,~~ ~~otherwise prepared and submitted by~~ on-call is to be provided. Changes to the ~~Division Head. Alterations~~call schedule must be clearly disseminated ~~by the Division Head or delegate~~in advance to all necessary recipients.

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~~(vii)~~2.3.7.2 The frequency of call is ~~dictated~~determined by both ~~by~~ the needs of the patient and the size of the on-call group.

2.3.7.3 ~~When on~~On-call~~, group members will be expected to~~ Practitioners shall maintain ~~acceptable levels of~~ availability~~.~~ dictated by the patient's condition and clinical requirements.

~~(b)~~2.3.7.4 Departments~~/~~ and Divisions that deal with life~~/~~, limb~~/~~, and organ~~-~~threatening emergencies shall ~~delineate the method of obtaining~~establish a process to obtain assistance when the first ~~member~~ on-call member cannot respond within ~~these timeframes~~an appropriate timeframe.

2.3.8 ~~Exemptions~~On-call exemptions

~~(3)~~ A Practitioner may be exempted from ~~being~~providing on-call~~:~~

~~(a)~~2.3.8.1 ~~With~~ coverage only when approved by the ~~approval~~Board, acting on the advice of the ~~Senior Medical Administrator, a~~ HAMAC and the applicable Department Head~~, upon discussion with and recommendation by the relevant Division Head, may excuse an individual member from on-call duties, either temporarily or permanently.~~.

2.3.8.2 ~~The criteria upon which a~~ In an urgent situation or in an emergency, the CMO may grant a temporary exemption from providing on-call coverage. In this circumstance, the Department Head ~~can create an exemption must be agreeable~~or delegate shall exercise all means available to ~~all Division Heads within the~~ find a replacement.

~~(b)~~2.3.8.3 The Department ~~and must be discussed~~Head, in consultation with the ~~members of the~~ Division Heads and Department members, shall establish written criteria for requesting an exemption for its members from on-call responsibilities. A Department or Division can only request an exemption for a member if the other Department or Division members are prepared to ~~seek consensus~~fulfil that member's on-call obligations.

~~(c)~~2.3.8.4 Criteria for partial or full exemptions may include, but are not limited to:

(i) Age of the member;
(ii) Health concerns;
(iii) Extraordinary personal circumstances; or
(iv) Other ~~balancing obligations~~offsetting contributions by the member to the Department~~/~~ or Division.

~~(d) Exemptions, reasons for exemptions, degree of permanence and changes to exemptions shall be recorded by the Department Head for inclusion in the privileging documents of the member.~~

2.3.8.5 The Department Head shall provide the HAMAC with reasons for a proposed exemption, any changes to an already-existing exemption and the potential

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consequences of an exemption, which will assist the HAMAC to provide an appropriate recommendation to the Board.

2.4 Medical Staff Association ~~– PENDING FURTHER REVIEW – PLEASE CURRENTLY OMIT FROM CONSIDERATION~~

The Health Authority Medical Staff Association (HAMSA) is ~~an Island Health~~a VIHA-wide entity operating in accordance ~~to~~with Article ~~10 of Island Health's Bylaws.~~11 of the Bylaws.

~~(A)1.5.1.1 Purpose~~

2.4.1 Purpose

2.4.1.1 The HAMSA ~~is the association~~shall consist of all members of the Medical Staff, and~~,~~ ~~as such, speaks for~~ shall:

(i) represent the views of its members ~~as individuals~~both individually and ~~as a collective. HAMSA is~~ collectively; and

(ii) be responsible for effective ~~communications between~~communication with the Medical Staff, ~~administration and the Board of Directors. The HAMSA shall consist of all members of the Medical Staff.~~Administration and the Board.

~~(B)1.5.1.1 Composition~~

2.4.2 Composition

2.4.2.1 The HAMSA will be ~~composed of a conglomerate of local chapters (Local~~represented by the elected members of Site Medical Staff Associations~~).~~.

~~(C)~~2.4.3 Local Medical Staff Association (LMSA) Meetings~~:~~

2.4.3.1 Meetings of the ~~local chapters (Local Medical Staff Association – LMSA)~~LMSAs will be held at least four times per year~~, one of those being recognized as~~. One meeting will be an annual general meeting ~~at which time~~where officers of the LMSA ~~will~~shall be elected for the coming year.

~~(1)~~2.4.3.2 The CEO ~~of Island Health and/or the Senior Medical Administrator or delegate(s) will~~and the CMO or their delegates shall be invited to attend at least one of the meetings per year.

~~(2) Duties of a Local Medical Staff Association~~

~~(a) Advise the MSA through its Executive Committee of the concerns and opinions of the local Members of Medical Staff;~~

~~(b) Arrange for collection of annual fees and administer Medical Staff funds of the LMSA as determined from time to time;~~

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~~(c) Create and administer programs of interest to the members of Medical Staff at the local site, regional areas or Island-wide in scope;~~

~~(d) Meet at the call of the President/Chair to nominate a candidate to fill any position vacated during the term of office;~~

~~(e) Ensure a fair and equitable system of voting for officers by all members of the LMSA.~~

~~(f) Prepare a list of candidates for the elected positions of officers of the LMSA for the annual meeting of the Medical Staff in accordance with the obligations of a registered non-profit society;~~

~~(g) Invite nominations from the members of Medical Staff through a notice provided or made available to each member at least one month prior to voting. Any nominations must be received seven days prior to the~~A Special meeting~~.~~

~~(3) Meetings~~ of the LMSA

~~(a) Regular general meetings shall inform the Medical Staff of known actions recommended by the HAMAC. Department and committee reports~~ may be ~~presented at these meetings.~~

~~(b)~~2.4.3.3 ~~General meetings, including special meetings, may be convened at any time and shall be~~ called ~~by the elected officers of the LMSA or~~ at the request of at least 10% of the ~~members~~membership of the ~~associated Medical Staff~~LMSA who are eligible to vote.~~ (current privileges held).~~

~~(c)~~2.4.3.4 Notification of a meeting must be given at least seven (7) days and not more than 60 days before the meeting.

~~(d)~~2.4.3.5 Where applicable, notice of a general meeting must include any special resolution to be submitted for consideration.

~~(4) Attendance:~~

2.4.4 ~~Active and provisional members of~~Duties of the Local Medical Staff Association

2.4.4.1 The LMSA shall:

(iii) Advise the Medical Staff through the LMSA Executive Committee of the concerns and opinions of its members;
(iv) Set the rate and arrange for the collection of annual fees from all members;
(v) Administer LMSA funds as determined by the membership;
(vi) Create and administer programs of interest to the members of the Medical Staff locally, regionally or Island-wide;
(vii) Meet at the call of the President to nominate a candidate to fill any position vacated during the term of office;

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(viii) Ensure a fair and equitable system of voting for the LMSA Executive;

(ix) Prepare a list of candidates for the LMSA Executive for presentation at the annual meeting of the Medical Staff Association; and

(x) Invite nominations from the members of Medical Staff through a written notice provided to each member at least one month prior to voting; Nominations must be received seven days prior to the meeting.

(xi) The Medical Staff shall be informed at regular general meetings of the business, advice and recommendations provided by the HAMAC. Department and committee reports released by the HAMAC may be presented at these meetings.

2.4.5 Attendance

2.4.5.1 Medical Staff members are encouraged and expected to attend ~~at least~~ 50% or more of ~~the local~~their LMSA meetings in a calendar year to stay informed and to ensure that their voice is considered ~~and heard; and to remain informed~~in conducting the business of the LMSA.

~~(5) Quorum:~~

2.4.5.2 A simple majority ~~will~~(50%+1) shall constitute a quorum~~.~~ for voting purposes.

~~(6)~~2.4.6 Officers~~:~~

~~(a)~~2.4.6.1 ~~The election of and the duties of elected~~The officers of ~~the~~ LMSA Executive shall consist of ~~a minimum of~~:

(i) President/Chair
(ii) Vice-President
(iii) Secretary/Treasurer

~~(b)~~2.4.6.2 Officers shall serve a term of one year in a given position ~~before~~and may be re-~~election to~~elected for a maximum of three consecutive years in office.

~~(c)~~2.4.6.3 The duties of elected officers are outlined in ~~the Bylaws~~ Article ~~10~~11.2 of the Bylaws.

2.4.6.4 To prevent the perception or allegation of conflict of interest, LMSA Officers may not simultaneously hold a VIHA leadership role as Medical Director, Medical Lead, Department Head, Division Head or Section Head.

2.4.6.5 The LMSA president or delegate sits as a voting member of the LMAC and LQOC at facilities within the jurisdiction of the LMSA.

~~(D)~~2.4.7 HAMSA Executive Committee (HEC)

2.4.7.1 Purpose

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~~(1) Officers may not hold an administrative position in the Health Authority Medical Staff Association Executive Committee for Island Health~~

~~(2) Purpose:~~

~~(a) To represent the interests of members of Medical Staff~~

~~(b) To provide support to LMSA regarding issues of medical professional management~~

~~(3) Responsible to:~~

~~(a)~~2.4.7.1.1 This Committee is responsible to the Medical Staff of Island Health.

2.4.7.1.2 The HEC:

(i) Represents the collective voice of the Medical Staff members;
(ii) Supports and advises LMSAs in their ongoing work; and
(iii) Works with the Health Authority to establish Island-wide medical-staff engagement strategies.

2.4.7.2 Composition

~~(4) Composition:~~

~~(a)~~2.4.7.2.1 The HAMSA Executive Committee is composed of ~~the~~all LMSA Presidents ~~of the LMSAs throughout Island Health, or~~ or their delegates.

~~(5)~~2.4.7.2.2 Officers of HAMSA Executive Committee include:

~~(a)~~ Chair~~President~~

(i)
~~(b)~~(i) Vice-~~president~~Chair
~~(c)~~(i) Secretary

~~(d)~~ Officers shall ~~serve~~ be elected for a ~~term of~~ one-year term in ~~a given position before~~ and may be re-~~election to~~elected for a maximum of three consecutive years in that office.

~~(e)~~2.4.7.3 The ~~President~~Chair of the HAMSA Executive Committee sits on HAMAC as a voting member.

~~(f)~~2.4.7.4 The duties of elected officers are outlined in Article 11.2 of the Bylaws ~~Article 10.2~~.

~~(6) Quorum:~~

~~(a)~~2.4.7.5 A simple majority (50%+1) will constitute a quorum.

~~(7)~~ Meetings~~:~~

~~(a)~~2.4.7.6 ~~Meetings will be scheduled and held~~ shall occur at least ~~five~~four times ~~per year~~

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~~or~~annually and at the call of the ~~HAMSA Executive Committee President~~Chair.

~~(b)~~2.4.7.7 The VIHA CEO ~~of Island Health, Senior Medical Administrator or delegate(s),~~ CMO and HAMAC Chair ~~of the HAMAC~~or their delegates may be invited to attend or may request to attend these meetings.

~~(8)~~2.4.7.8 Duties~~:~~

2.4.7.8.1 ~~Advise~~The HAMSA:

~~(a)~~(i) Advises the HAMAC and ~~Island Health~~VIHA of the concerns and opinions of ~~the~~its members ~~of Medical Staff and provide an avenue for advocacy of these concerns~~and advocates on their behalf;

~~(b)~~(ii) ~~Provide~~Provides a forum for LMSAs ~~jointly~~ to discuss and develop initiatives and ideas of mutual interest;

(iii) ~~Ensure~~Encourages members of the Medical Staff to run for office on the LMSA Executive Committees; and

(iv) Ensures that ~~LMSAs prepare~~each LMSA prepares a list of candidates for ~~the elected~~its Executive positions and conducts a fair and timely election process.

~~(c)~~2.4.7.9 To prevent the perception or allegation of ~~officers~~conflict of ~~the LMSA for the annual meeting of the~~interest, HAMSA Officers may not simultaneously hold a VIHA leadership role as Medical Director, Medical ~~Staff;~~Lead, Department Head, Division Head or Section Head.

~~(d) Ensure invitations for nominations to officers of the LMSAs are encouraged from the members of Medical Staff.~~

2.5 Medical Staff Committees

~~(A)~~ General Principles of Governance and ~~Operations~~Operation:

~~(1)~~2.5.1 A simple majority ~~(50% +1)~~ of voting members (50% +1) shall constitute a quorum for the HAMAC and all its subcommittees. A meeting may take place ~~where~~without quorum ~~is not achieved~~ but no business ~~will~~can be carried out or motions made~~, without quorum~~.

2.5.2 Voting at all Medical-Staff committee meetings is limited to those members of the Medical Staff whose appointment category permits them to do so.

~~(2)~~2.5.3 Meetings will operate ~~on~~by consensus~~; where a~~. Where consensus is not ~~achievable~~possible, motions will be decided by a simple majority ~~of those eligible to~~ vote ~~who are~~of members present in person or by ~~telephonic, electronic or other communication devices.~~proxy. In case of a tie, the ~~meeting chair~~Chair shall ~~have~~cast the deciding vote.

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~~(3) Voting membership on all Medical Staff committees is limited to members of the Medical Staff of Island Health.~~

~~(4)~~2.5.4 Where ~~there is~~a procedural query or process dispute ~~regarding any aspect of a meetings' procedure~~arises at a Medical-Staff committee meeting, the most current version of Roberts Rules of Order ~~will~~shall be followed.

~~(5)~~2.5.5 All meetings will be minuted and ~~documented according to~~in accordance with the Medical Staff Committee Governance Standards.

~~(6)~~2.5.6 ~~Representation~~Each HAMAC sub-committee chair shall provide the names of all ~~standing subcommittees will be provided~~committee members to the HAMAC secretariat ~~on an annual basis.~~ annually and when changes occur.

2.5.7 The office of the CMO provides secretariat support to the HAMAC and its sub-committees as described in the Bylaws.

~~(7)~~2.5.8 All Medical Staff Committees are ~~subcommittee~~subcommittees of the HAMAC and ~~carry out regular reporting~~report regularly to the HAMAC ~~based~~ on proceedings at meetings.

~~(8) Voting by proxy is permissible only if the committee chair has received notification from the committee member identifying the proxy at least 48 hours before the meeting. The proxy must be a member of the Medical Staff of Island Health.~~

~~(B)~~2.5.9 Health Authority Medical Advisory Committee

~~(1)~~2.5.9.1 Purpose and Responsibilities

~~(a)~~2.5.9.2 The ~~Health Authority Medical Advisory Committee (~~HAMAC~~)~~ is the ~~representative~~senior advisory committee of the Medical Staff as defined in Article 8 of the Bylaws. ~~The HAMAC make recommendations to the Board of Directors with respect to:~~

2.5.9.3 ~~the appointment~~The HAMAC makes recommendations to the Board with respect to:

(i) Appointment and review of members of the VIHA Medical Staff ~~within Island Health~~, including the delineation of clinical and procedural Privileges;

~~(ii) disciplinary measures for violation of the Bylaws, Rules, or policies governing the conduct of the Medical Staff;~~

(ii) ~~the~~The quality, effectiveness, and availability of medical care provided within VIHA Facilities and Programs;

(iii) The establishment and maintenance of professional standards in Facilities and Programs ~~funded and~~ operated by ~~Island~~

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~~Health~~VIHA in compliance with all relevant legislation, the Bylaws, Rules, and policies;

(iv) ~~the resource requirements of~~The resources required by the Medical Staff to meet the needs of the population served by ~~Island Health~~VIHA including, but not limited to, the availability and adequacy of existing resources to provide appropriate patient care;

(v) ~~continuing education~~Continuing Professional Development (CPD) of the ~~members of~~ Medical Staff;

~~(vi) planning goals for meeting the medical care needs of the population;~~

~~(vii)~~(vi) ~~concerns related to the~~The professional and ethical conduct of members of the Medical Staff ~~and, where appropriate, report those concerns to the appropriate Regulatory College;~~; and

~~(viii) The quality, effectiveness, and availability of medical care provided, in relation to professional standards, within Island Health Facilities and Programs.~~

(vii) Disciplinary measures for violation of the Bylaws, Rules and policies governing the conduct of the Medical Staff.

~~(b)~~2.5.9.4 The HAMAC receives information from ~~the~~its subcommittees, ~~departmental~~medical Departments and ~~programmatic sources~~clinical programs, and ~~reports~~provides advice to the Board ~~of Directors~~ on ~~the requirements outlined within the Bylaws~~based on that information.

~~(2)~~2.5.9.5 Appointments to HAMAC:

~~(a) The Chair of the HAMAC is appointed by the Board of Directors on the recommendation of the HAMAC.~~

(i) ~~The~~and Vice-Chair of the HAMAC ~~is selected from among the voting membership of 3 (c), 3 (d) or 3 (e) listed below and is~~are appointed by the Board ~~of Directors~~ on the recommendation of the HAMAC. ~~The Vice-Chair is~~ and the CMO.

~~(b)~~(ii) The Chair and Vice-Chair shall normally be selected from among the voting members of the HAMAC but may be selected from other members of the Active Medical Staff. The Chair and Vice-Chair are appointed for a term of not more than three (3) years and may be reappointed for up to three (3) consecutive terms.

~~(c) The membership of the voting and non-voting HAMAC will be appointed by the Chair of HAMAC following consultation and input from the HAMAC~~

~~(d) The membership is confirmed annually, at the organizational meeting; interim membership changes will be carried out at the discretion of the~~

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~~Chair~~ ~~following consultation and input from the HAMAC. There is no maximum term for regular voting or non-voting members.~~

~~(e) The Executive Committee will be appointed by the Chair of HAMAC with consultation and input from the HAMAC; HAMAC Executive will be confirmed annually, at the organizational meeting outlined below. There is no maximum term for executive members.~~

~~(f) Any membership disputes will be dealt with by a vote of the HAMAC.~~

~~(3)~~2.5.9.6 Voting Members:

~~(a)~~(i) Chair of the HAMAC

~~(b) Chief Medical Officer~~

(ii) Vice-Chair of the HAMAC

(iii) Vice President Medicine, Quality and Academic Affairs

~~(c)~~(iv) Each VIHA Department Head ~~of Island Health~~ or delegate

~~(d)~~(v) ~~An~~One LMAC Chair~~/Chief of Staff representative~~ from each ~~geography~~of the four geographies

~~(e)~~(vi) ~~An~~One MSA representative from each ~~geography~~of the four geographies, one of whom ~~will~~shall be the HAMSA ~~president~~Executive Committee Chair

~~(f)~~(vii) Chief Medical Health Officer

~~(g)~~(viii) Chief Medical Information Officer

~~(4)~~2.5.9.7 Non-voting Members:

~~(a)~~(i) President and CEO

~~(b)~~(ii) All Executive Medical Directors of Island Health

~~(c)~~(iii) HAMAC standing subcommittee Chairs

~~(d)~~(iv) General Legal Counsel & Chief Risk Officer

~~(e)~~(v) Executive Vice-President, Quality, Safety & Experience

~~(f)~~(vi) Other members of the senior administrative or Medical Staff of ~~Island Health~~VIHA as appropriate and as agreed ~~by~~between the HAMAC Chair and CMO~~.~~.

~~(5) Executive Committee~~

2.5.9.8 ~~An~~The HAMAC shall review and ratify its voting and non-voting membership at the annual HAMAC Planning Meeting. Between Annual Planning meetings membership may change based on the appointment of new incumbents into voting and non-voting positions.

2.5.9.9 The HAMAC Executive Committee shall be appointed by the Chair of HAMAC in consultation with the CMO and with input from the HAMAC. The HAMAC Executive membership will be ratified at the Annual HAMAC Planning Meeting.

2.5.9.10 The Executive Committee shall ~~be formed to support the composition and finalization of~~ plan, develop, prioritize and finalize the agenda items for each regular

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meeting, as well ~~as to~~ deal with business arising between meetings ~~as required by~~at the request of the Chair~~.~~ or CMO.

2.5.9.11 The executive committee shall be comprised of:

~~(a)~~(i) Chair of the HAMAC
~~(b)~~(i) Vice-Chair of the HAMAC
~~(c)~~(ii) Chief Medical Officer
~~(d)~~(iii) One MSA representative who is a voting member on the HAMAC
~~(e)~~(iv) Two Department Heads

~~(6)~~2.5.9.12 Regular Meetings

~~Meetings of the~~The HAMAC shall ~~be held~~meet a minimum of five times per year ~~and be aligned~~in alignment with the scheduled meetings of the Board ~~of Directors meetings.~~. One of the five meetings will be designated as the organizational meeting as outlined below~~.~~:

~~(b)~~(v) The agenda and related material will be distributed to the membership not less than one week before any regular meeting.
~~(c)~~(vi) Attendance at regular meetings of the HAMAC will be limited to the membership as set out in the membership composition or by invitation of the HAMAC Chair or Executive.
(vii) There is no maximum term for voting, non-voting and executive members of the HAMAC.

2.5.9.13 Executive Committee

~~(7)~~2.5.9.13.1 Special Meetings

The HAMAC may meet to ~~deal with~~address special issues or urgent ~~issues. In such event, the latest version of Robert's Rules of Order for~~matters. The special ~~meetings is to be followed.~~

~~(a)~~(i) ~~Special~~ Meetings are ~~called~~held at the ~~direction~~call of the Chair or by request of a ~~consensus~~majority of members of the HAMAC ~~executive~~Executive.
~~(b)~~(ii) A minimum of four days' notice is required for special meetings unless otherwise noted within these Rules.
~~(c)~~(iii) ~~Attendance at~~All members may attend special meetings of the HAMAC ~~will be limited to the~~ but a quorum of voting members of the HAMAC~~; others~~ is required for the meeting to proceed. Others may attend by invitation of the Chair or the HAMAC Executive.

~~(8)~~2.5.9.13.2 Organizational Meeting

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~~(a)~~(i) Annually, ~~one of the meetings of~~ the HAMAC shall ~~be~~hold a face-to-face meeting open to ~~attendance from~~ the HAMAC ~~membership~~members, all Chairs of HAMAC subcommittees and others at the ~~direction~~discretion of the HAMAC Chair ~~and/~~or ~~HAMAC~~the Executive.

~~(b)~~(i) In compliance with the Bylaws, a video-~~-~~conference meeting will be ~~accepted~~construed as a face-to-face meeting.

~~(c)~~(ii) Quorum for the organizational meeting ~~is represented by~~ will be a simple majority of the regular HAMAC voting membership.

~~(d) On an annual basis, the Chair may invite other medical and/or non-medical representation as deemed appropriate.~~

~~(e)~~(iii) The meeting will be for the purpose of receiving reports and confirming membership of the HAMAC and its' subcommittees. Standing subcommittee reports ~~will~~shall include, ~~but not be limited to~~at a minimum, work completed over the previous year, and goals ~~and challenges~~ for the coming year.

~~(9)~~2.5.9.14 Role and Responsibilities of the HAMAC Chair

2.5.9.14.1 The Chair:

~~(a)~~(i) Acts as the principle spokesperson for the HAMAC in ~~liaisons~~liaising with the CEO, the CMO and the Board of Directors;

~~(b)~~(ii) Presides at all meetings of the HAMAC~~.~~;

~~(c)~~(iii) Manages the affairs of the HAMAC between meetings, ensuring ~~the~~that committee responsibilities are discharged in a timely manner~~.~~;

~~(d)~~(iv) Oversees the secretariat in coordinating and ensuring timely reporting ~~to HAMAC of~~by the subcommittees~~.~~ to HAMAC;

~~(e)~~(v) Serves as an ex-officio ~~non-voting~~ member of all HAMAC subcommittees ~~of which he/she is not a member.~~;

~~(f)~~(vi) Oversees the annual confirmation of the HAMAC membership ~~of the HAMAC~~ and ~~directs the appointments to committee chairs as outlined within these Rules.~~appoints subcommittee Chairs;

~~(g)~~(vii) Communicates ~~to the HAMAC, the standing subcommittees, the MSAs and the wider~~ broadly to the Medical Staff on ~~HAMAC and/or any concerns and issues identified by the Authority~~ business ~~as appropriate.~~decisions, motions and advice provided by the HAMAC;

~~(h)~~(viii) Reports to and attends meetings of the Board of Directors~~.~~; and

~~(i)~~(ix) ~~Other~~ Performs other duties as required by the CEO or the Board.

2.5.9.15 Local Medical Advisory Committees (LMACs)

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(i) The LMAC is a site-specific committee chaired by the Chief of Staff and Site Medical Director, who shall report to the HAMAC on its minuted business and approved motions.

(i) Where two acute-care sites function as one, a combined LMAC may be formed on the recommendation of the HAMAC.

2.5.9.16 LMAC Membership

(i) The Chair who is the Chief of Staff and Site Medical Director;

(ii) The President of the site MSA;

(iii) Other site-specific members of the medical staff or Island Health administration as deemed appropriate by the chair.

2.5.9.17 Each site will determine the membership of the LMAC from Department, Division and Section Heads in their site or geography.

2.5.9.18 Frequency of LMAC Meetings

(i) The LMAC will meet a minimum of 6 times per year or at the call of the Chief of Staff.

(ii) The following VIHA Facilities shall establish and maintain LMACs:

(1) Cowichan District Hospital

(2) Nanaimo Regional General Hospital

(3) North Island Hospital (Campbell River Hospital and Comox Valley Hospital)

(4) Saanich Peninsula Hospital

(5) South Island Tertiary Hospitals (Victoria General Hospital and Royal Jubilee Hospital)

(6) West Coast General Hospital

~~(C)~~2.5.9.19 Standing Subcommittees

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2.5.9.19.1 The ~~operational~~ mandate for each standing subcommittee of the HAMAC is outlined ~~within~~in these Rules. ~~All subcommittees support the recommendations that HAMAC is mandated to make to the Board of Directors as per the Bylaws.~~ The Board ~~of Directors~~, on the advice of the HAMAC, may establish other committees ~~and/or~~as well as additional Local Medical Advisory Committees as outlined in Article ~~9~~10.1 of the Bylaws.

2.5.9.20 Chair and Vice-Chair Appointments to Standing Subcommittees

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(i) The Chair of the standing subcommittee is appointed by the HAMAC from eligible members of the Medical Staff ~~Bylaws.~~.

(ii) The Chair is appointed for a term of not more than three (3) years and may remain in the position for up to three (3) consecutive terms, for a total of nine (9) years.

(iii) A Vice-chair is appointed by the Chair of the standing subcommittee and is selected from the voting membership of that standing subcommittee.

(iv) The Vice-chair of the standing subcommittee is appointed for a term of not more than three (3) years and may remain in the position for up to three (3) consecutive terms, for a total of nine (9) years.

2.5.9.21 Role and Responsibilities of Chair of Standing Subcommittees

2.5.9.21.1 The Chair shall:

(i) Act as the principle spokesperson for the standing subcommittee;
(ii) Preside at all meetings of the standing subcommittee;
(iii) Manage the affairs of the standing subcommittee between meetings, ensuring the committee responsibilities are discharged in a timely manner; and
(iv) Ensure the appropriate and timely reporting of minuted business and approved motions of the standing subcommittee to the HAMAC.

2.5.9.21.2 The Vice Chair assumes the role of Chair in the Chair's absence.

~~(1)~~2.5.9.22 Medical Planning and Credentials Committee (MPCC)

2.5.9.22.1 Purpose and Responsibilities

(i) The role of the MPCC ~~includes the requirements of~~ is outlined in Article 4.3 of the Bylaws.

~~(a) The MPCC provides the link between the work of the Medical and Academic Affairs portfolio and the Medical Staff. The committee provides advice and guidance and governance oversight into the processes, policies and projects of Medical and Academic Affairs and reports this information into the Medical Staff structure.~~

~~(b)~~(ii) The MPCC is responsible for ~~the~~ reporting and making recommendations ~~and reporting~~ to the HAMAC on ~~the provision of~~:

~~(i) Advising Medical and Academic Affairs to ensure process, policy, and good governance is carried out in the following areas:~~

(1) Medical Staff recruitment;
(2) Credentialing, privileging, appointment and reappointment;
~~•~~(3) Medical Staff performance review and ~~reappointments~~;

~~• Performance reviews~~

~~• Recruitment and recognition~~

~~• Enhanced Medical Support Systems~~

~~(c)~~(4) ~~Ensuring equitability to processes affecting~~ Medical Staff ~~and within Medical and Academic Affairs~~recognition.

(iii) In addition, the MPCC is responsible for:

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~~(d)~~(1) Facilitating resolution ~~to~~of recruitment~~/credentialing~~ and privileging issues that cannot be resolved at the Department or Division level.

~~(e)~~(2) Providing ~~guidance~~advice on projects~~/~~ and initiatives ~~that occur within~~undertaken by Medical and Academic Affairs ~~that are~~ related to the Medical Staff~~, as required~~.

~~Click Here to view the complete terms of reference for the MPCC~~

2.5.9.23 Voting Members

2.5.9.23.1 Voting members shall be as follows:

(i) Chair
(ii) An operational Executive Medical Director
(iii) Medical Director, Credentialing, Privileging and Medical Staff Recruitment & Retention
(iv) Each Department Head or delegate

2.5.9.24 Non-Voting Members

(i) An operational Executive Director
(ii) Director Medical Staff Support
(iii) Manager Credentialing & Privileging and Medical Staff Recruitment & Retention
(iv) Two Members-at-Large

2.5.9.25 Frequency of Meetings

(i) The MPCC will meet a minimum of 10 times per year ensuring that the meeting is scheduled to align with HAMAC reporting requirements. Additional meetings may take place at the call of the chair.

~~(2)~~2.5.9.26 Legislative Committee (LC)

2.5.9.26.1 Purpose and Responsibilities

~~(a)~~(i) The Legislative Committee (LC~~ is purposed with the oversight, management, evolution~~) makes recommendations to the HAMAC on the development, implementation, monitoring and revision of the ~~Rules in accordance with the~~VIHA Medical Staff Bylaws~~.~~, Rules and Policies.

~~(b) The LC provides, as required or as requested by the HAMAC, proposed changes to both Rules and Bylaws for consideration and recommendation by the HAMAC to the Board of Directors.~~

~~(c) The Rules are considered a "living" document requiring periodic adjustment in keeping with changing times and circumstances, amenable to revision and adaptation to the modern Practitioner/health authority interface.~~

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~~Click Here to view the complete terms of reference for the LC~~

(i) Changes to the Bylaws must be approved in writing by the CEO, Board Chair and Minister of Health. Changes to the Rules must be approved in writing by the Board.

(ii) The Rules should undergo regular review and renewal to reflect changes in the clinical-practice environment.

2.5.9.27 Voting Members

(i) Chair of the Legislative Committee

(ii) A minimum of 5 voting members of the HAMAC

(iii) The Vice President Medicine, Quality and Academic Affairs (or delegate)

(iv) Other members of the Medical and/or hospital staff as the Committee deems appropriate.

2.5.9.28 Non-Voting Members

(i) Consultants and advisors as deemed appropriate by the HAMAC

2.5.9.29 Frequency of Meetings

(i) The Legislative Committee shall meet as required to meet its purposes and responsibilities at the call of the Chair.

~~(3)~~2.5.9.30 Medical Education Committee (MEC)

2.5.9.30.1 ~~To advise~~Purpose and Responsibilities

(i) The MEC supports the HAMAC ~~on~~by addressing policy and procedures related to clinical-trainee education ~~matters~~and medical staff continuing professional development as outlined in ~~Island Health relating to~~ Article 9.3.6 of the Bylaws.

2.5.9.31 Specifically, the MEC is responsible for making recommendations and reporting to the HAMAC on:

~~(a)~~(i) Educational opportunities for Medical Staff, Clinical Fellows, Residents, and ~~Medical~~ Students~~.~~ working in VIHA;

~~(b) To advise the HAMAC on matters relating to Education.~~

~~(c)~~(ii) ~~To advise on all~~Logistical matters relating to Clinical Fellows, Clinical Trainees, Residents and Students, ~~including their welfare,~~ such as the provision of on-call facilities, ~~appointments, educational programs, evaluations and discipline.~~health protection services, and code of conduct;

~~(d)~~(iii) ~~To assist all~~Assisting Divisions, Departments~~, Divisions~~ and ~~Programs~~programs in the planning and coordination of ~~all~~ educational activities~~ of the Medical Staff, Clinical Fellows, Clinical Trainees, Residents and ;Students within Island Health and the community.~~

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~~(e)~~(iv) ~~To advise~~Advising the HAMAC of rounds, clinical conferences, lectures and symposia being given ~~in~~by each Department~~.~~;

~~(f)~~(v) ~~To assist~~Assisting Divisions, Departments and ~~Programs~~programs in setting policies for continuing ~~education.~~professional development; and

(vi) ~~To provide~~Providing representation ~~to~~on the ~~Island Health~~VIHA Library Committee ~~in accordance~~.

2.5.9.32 Voting Members

(i) MEC Chair;

(ii) A representative from each Department responsible for learners;

(iii) A representative from the Division of Public Health and Preventative Medicine; and

(iv) A medical-staff representative of the First Nations Health Authority.

2.5.9.33 Non-Voting Members

(i) Three learner representatives;

(ii) A representative from rural and remote sites;

(iii) The Regional Associate Dean for the Island Medical Program; and

(iv) Consultants and advisors as the Committee deems appropriate.

2.5.9.34 Frequency of Meetings

~~(g)~~(i) The MEC will meet a minimum of four (4) times per year ensuring that each meeting is scheduled to align with ~~the University Affiliation Agreement.~~HAMAC to meet reporting requirements. Additional meetings may take place at the call of the chair.

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~~Click Here to view the complete terms of reference for the MEC~~

~~(4)~~2.5.9.35 Health Authority Medical Quality Committee (HAMQC)

~~(a)~~(i) ~~The~~ Reporting to the HAMAC, the HAMQC ~~provides the link between the quality of medical care and Medical Staff structures. The committee provides~~aligns with the VIHA Quality Improvement structure and committees to provide advice and guidance ~~into the quality structure, as required, and reports~~ on those aspects of quality~~, safety~~ improvement and patient ~~experience data.~~ safety that fall within the purview of the VIHA Medical Staff.

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~~(b)~~(ii) The HAMQC is responsible for the making recommendations ~~and reporting~~ to the HAMAC on ~~the provision of~~:

~~(i)~~(1) ~~Reviewing and advising on medical~~Medical staff quality assurance data and measures~~;~~

~~(ii)~~(1) ~~Reviewing and advising on medical~~Medical quality improvement initiatives ~~and systems as deemed necessary;~~

~~(iii)~~(2) ~~Supporting the development~~Development and implementation of ~~Island Health~~ VIHA QA/QI programs~~;~~ and

~~(iv) Reviewing and providing guidance on~~Medical Staff-related issues identified by HAMAC ~~as impacting on patient quality~~

~~Click Here to view the complete terms of reference for the HAMQC~~

~~(5) Oversight Committee (OSC)~~

~~(a)~~(3) ~~Review current and emergent issues identified through the HAMAC that will/may significantly~~ that impact the ~~work of Medical Staff and make recommendations to HAMAC~~quality of patient care.

~~(b) To make recommendations to HAMAC to ensure equitable implementation of the Medical Staff Bylaws and Rules~~

2.5.9.36 ~~Click Here to view the complete terms of reference for the OSC~~Voting Members:

(i) The Chair of the HAMQC;
(ii) Three (3) Department Heads or delegate;

Four (4) Chiefs

~~(6) Local Medical Advisory Committee (LMAC) and Local Medical Coordinating Committee (LMCC)~~

~~(a) Where two tertiary care sites function as one unit, a combined LMAC (GMAC) may be formed, at the discretion of the HAMAC.~~

~~(b) Those sites that do not have Departmental leadership will develop a Local Medical Coordinating Committee (LMCC) made up of medical leads.~~

~~(c)~~(iii) ~~The LMAC is a site-specific committee accountable to the Chief~~ of Staff/Site Medical Director~~, who shall report on its functioning and discussions to HAMAC.~~ or delegate (one from each geography);

~~(d) This collaborative committee provides advice and recommendation to the Chief of Staff/Site Medical Director as it applies to Departmental functions and professional services at the site. These functions include:~~

(iv) ~~Medical~~ Medical Director, Residential Care, or delegate;
(v) A Medical Staff Association president; and

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(vi) A medical staff representative from the First Nations Health Authority.

2.5.9.37 Non-Voting Members

(i) Vice President Medicine, Quality and Academic Affairs;
(i) A representative from the Combined Quality Oversight Council (CQOC);
(ii) A representative from the Quality Operations Council (QOC);
(iii) The Chief Medical Information Officer or delegate;
(iv) An Island Health medical staff learner; and
(v) An approved patient representative.

2.5.9.38 Frequency of meetings

(i) The HAMQC will meet a minimum of 6 times per year far enough in advance of scheduled HAMAC meetings to ensure timely reporting to the HAMAC. Additional meetings may take place at the call of the chair.

2.5.9.39 These collaborative committees provide advice and recommendations to HAMAC on:

(i) Medical-Staff workforce planning;
(ii) Credentialing and privileging;
(iii) ~~Performance~~Individual provider practice quality and performance enhancement ~~and individual provider quality;~~
(iv) ~~Unprofessional behaviour and~~Professional development;
(v) Practice standards and documentation;
(vi) ~~Research and medical~~ Medical education and research; and

~~Click Here to view the complete terms of reference for the LMAC~~
~~Click Here to view the complete terms of reference for the LMCC~~

(vii) Meeting standards of professional behaviour.

~~(D)~~2.5.9.40 Ad Hoc Committees

~~(1)~~2.5.9.41 Department Head Search Committee ~~for Department Heads~~(DHSC)

~~Coordinate~~The DHSC works with the ~~search and review process for each~~Chief Medical ~~Department Head.~~Officer and Medical Affairs staff to:

~~(b)~~(i) Develop a position description for the Department Head ~~with~~including a list of ~~the~~required qualifications ~~to be met.~~;
~~(c)~~(ii) ~~Arrange to advertise~~Advertise the position in accordance with established ~~Island Health~~ VIHA protocols~~.~~;
(iii) Coordinate the search and review process;
~~(d)~~(iv) Review ~~documents received~~applications and documentation from ~~all candidates.~~each candidate;
~~(e)~~(v) Develop a short list of candidates to be interviewed~~.~~;

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~~(f)~~(vi) Organize and conduct ~~a~~an interview process for each ~~candidate on the shortlist to be interviewed by the committee and other members of the Medical, Hospital and Administrative staff.~~short-listed candidate; and

~~(g)~~(vii) Report its recommendations to the HAMAC.

~~Click Here to view the complete Terms of reference for the Search Committee~~

~~(2)~~2.5.9.42 Disciplinary Review Committee (DRC)

2.5.9.42.1 ~~Act~~Purpose and Responsibilities

~~(a)~~(i) A DRC may be constituted to act as the investigative arm of HAMAC ~~when~~for issues ~~of~~requiring potential disciplinary action ~~are forwarded to HAMAC as part of the process envisioned~~described in Article ~~11.2~~12.2 of the Bylaws ~~and Article ___ of these Rules. This includes~~. These include but ~~is~~are not limited to issues relating to ~~disruptive~~unprofessional behaviour or ~~improper behavior, competency or credentialing concerns.~~clinical competence. The ~~exception is this committee~~ DRC does not address summary restriction~~/~~ or suspension as outlined in Article ~~11~~12.2.1 of the Bylaws ~~where in keeping with Article 11.2.1.5~~, which requires that the entire HAMAC ~~will~~ review these matters.

(ii) ~~Click Here to view~~In the ~~complete Terms~~interest of ~~reference~~procedural fairness and due process the following principles will govern the work of the DRC:

(1) Lawfulness – A disciplinary procedure must meet the criteria of procedural fairness as determined by the jurisprudence of the Court, and the provisions of relevant legislation and bylaws.

(2) Efficiency – A procedure should allow the resolution of an issue in a timely fashion, without undue expense and administrative dislocation. The procedure should operate in a smooth and predictable way, while at the same time respecting the duty of fairness to the practitioner who is subject to the procedure.

(3) Clarity – The process should be understandable and made known to all parties from the time practitioners are initially given privileges.

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(4) Legitimacy – All participants should perceive the process as legitimate. In particular, the process should be seen as legitimate by the medical staff.

(1) Timeliness – Proceedings should be concluded in a timely fashion in order to ensure protection of patients and to ensure the member of the medical staff is not subject to any long-term uncertainty that could adversely affect the reputation and income of the member of the medical staff. Matters should be concluded in the shortest possible time compatible with the full and careful consideration of the issue. The time constraints dictated by legislation shall be respected.

(iii) The remedial actions that the DRC may consider and recommend include:

(1) Reprimand;
(2) Restriction, modification, suspension or revocation of privileges; and
(3) Non-renewal of privileges.

2.5.9.42.2 Composition of the DRC

(i) Members are appointed as required by the HAMAC executive committee from the entire physician membership of the HAMAC and its subcommittees. Membership will include:

(1) One member of the HAMAC executive committee who shall serve as chair; and
(2) Two other neutral members of the HAMAC or its subcommittees.

2.5.9.42.3 Meetings of the DRC

(i) The committee shall meet at the call of the Chair.
(ii) Meetings shall be conducted in-camera.
(iii) All committee members must be present for all meetings.

2.5.9.42.4 Process

(i) A member under investigation has the right to be heard by the DRC and can choose to have legal counsel or an elected member of the Medical Staff Association present at that time.
(ii) A report summarizing the allegations, findings and recommendations of the DRC will be forwarded to the HAMAC Chair. Where discipline is recommended the HAMAC Chair shall schedule a special meeting of the HAMAC to review the recommendations of the DRC.

(iii) At the special HAMAC meeting, the Chair of the Discipline Committee will present the findings of the Committee and any recommendations. The member under investigation has the right to appear at the special meeting and make submissions to the HAMAC.

(iv) Following presentation of the DRC recommendations and a review of any submissions made to the HAMAC, the member under investigation, the members of the Discipline Committee and any others with a declared conflict of interest shall be excused from further deliberation. The Chair or Vice-Chair of the HAMAC will be the sole arbiter of whether a conflict of interest exists.

(v) For matters of clarification only, the Chair of the Discipline Committee may be asked back to the meeting during the deliberation. The member under investigation will be afforded the opportunity to be present and respond during the clarification.

(vi) The HAMAC will vote to accept in whole, modify or reject the recommendations of the DRC.

(vii) Where HAMAC accepts the recommendations in whole or with modification, the decision of the HAMAC will be communicated in writing to the member of the medical staff and forwarded to the Board for consideration. The member of the medical staff must be given at least seven days' notice in writing of any recommendation to the Board of Directors and of the date and time at which the recommendation will be considered in-camera by the Board of Directors. The member of the medical staff has the right to be heard at this meeting. All documentation provided to the Board must be made available to the member of the medical staff at the time notice is given. The Board of Directors must convey its decision to the member of the medical staff in writing within seven days.

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2.6 Teaching, Education and Research

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Medical Students and Residents are not members of the Medical Staff as defined in the Bylaws.

~~Island Health~~VIHA has entered into an affiliation agreement with the University of British Columbia that defines the processes for the placement of and responsibilities for training of UBC health ~~–~~ discipline students and residents within its Facilities and Programs.

Learner categories, undergraduate and postgraduate are defined by the College of Physicians and Surgeons of BC (CPSBC) and the College of Midwives of BC (CMBC).

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~~(a) Undergraduate Learners – Link to policy and procedure~~

~~(b) Postgraduate Learners – Link to policy and procedure~~

(B) Medical Staff Preceptors/Supervisors: (UBC: Resident Policies and Procedures)

(1) The affiliation agreement stipulates that UBC will provide suitable appointments to the University for those Practitioners who are significantly involved in teaching programs of the University, subject to the University's policies and procedures.

(2) To be involved in the teaching of UBC medical students and residents, Practitioners shall have a Faculty appointment with the UBC Faculty of Medicine (UBC Clinical Faculty).

(3) It is recommended that all Practitioners participate in teaching as a condition of their appointment to the Medical Staff.

(4) Practitioners are not responsible for facilitating onboarding or verifying that learners have met all the onboarding requirements as mandated by UBC and Island Health.

(5)1.5.1.1 Practitioners involved in teaching activities are responsible for ensuring that all learners are engaging in activities appropriate to their level of training. Learners are not to be placed in situations that may compromise safety.

(6) Practitioners must advise patients, or their designate, that residents may be involved in their care and obtain consent for such participation. Depending on the setting this may be done by way of signage or practice brochure with negative consent (opting out).

(7) Supervisors/preceptors must be available by phone or pager, when not available in person, respond in a timely manner and be available to attend to the patient in an emergency. When not immediately available, they must ensure that an appropriate alternate supervisor is available and has agreed to provide supervision.

(8) Supervisors/preceptors must assess, review and document resident competence in accordance with UBC specific policies.

(C)1.5.1 Research

Island Health views research as a core part of its purpose and encourages Medical Staff to contribute to the generation and application of evidence that will improve the quality of the treatments and services we deliver. The requirements and resources available for conducting research at Island Health are as follows:

(1) Individuals conducting research at Island Health must comply with Policy 25.3 Research Integrity, as well as any other applicable Island Health research policies and procedures.

(2) Research conducted at Island Health requires Island Health Research Ethics

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approval (Research: Ethics Application).

(3) Operational approval must be obtained from all Island Health Department(s) involved in the support or conduct of the research project (Research Ethics Operational Review)

(4) Individuals conducting clinical research at Island Health, defined as above minimal risk studies including an intervention involving human research participants, must be trained in Good Clinical Practice (GCP) as defined by the International Council on Harmonization (ICH).

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~~Article 3 - 1 Residential Facilities Operating under the Hospital Act~~

~~Island Health operates a number of residential care facilities under Part 2 of the *Hospital Act*. The responsibilities of Practitioners managing the care of patients in these facilities differ in some respects from acute care. This Chapter highlights unique rules that guide the care of patients in the residential care sector. Practitioners are otherwise expected to observe all of the Rules contained in the full document.~~

~~(A) 1.5 Most Responsible Practitioner (MRP)~~

~~(1) 1.5.1.1 The Most Responsible Practitioner (MRP) is identified initially as the Practitioner who agrees to accept a patient within a residential care Facility under his/her medical direction. The MRP may be determined either prior to, or at the time of, admission.~~

~~(2) The MRP is a shared care role in delivery of health and treatment services to patients. The MRP is the Practitioner responsible for directing and coordinating the care of a patient admitted to a Facility. However in urgent and institutional health safety situations where the MRP is not immediately available another duly qualified Practitioner may provide immediate care to a patient. The MRP will be subsequently informed of such care.~~

~~(3) During a patient's Facility stay, the role of the MRP may be transferred (*see below regarding transfer of care),~~

~~(4) The MRP is responsible for:~~

~~(a) Accepting patients for admission from acute care, another Facility, the community or transfer of care from a requesting Practitioner or Facility;~~

~~(b) Reviewing documentation and augmenting as required to ensure that a full medical assessment is documented, providing admission and continuing care orders.~~

~~(c) Working collaboratively with pharmacists and nurses to complete a Best Possible Medication History (BPMH) and ordering appropriate medications. Discharge orders from acute care shall be considered valid for up to seven (7) days, pending confirmation of the MRP.~~

~~(d) Providing periodic care, completing progress notes and overseeing the patient's care in the Facility, either directly or through an on-call group.~~

~~(e) Communicating with the patient, their next of kin and/or legally appointed Representative regarding medical conditions, any tests or consultations planned, and the results of such tests or consultations.~~

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(f) Working collaboratively with healthcare team members.

(g) When necessary, clarifying apparent treatment or management conflicts among shared-care providers.

(h) Attending each new admission (or readmission from acute care) to assess, conduct a review of documents and to confirm admission orders within seven (7) days of admission or re-admission.

(i) Proactively visiting each patient with an interval between visits of no more than 90 days.

(j) Attending annual multi-disciplinary care conference reviews whenever possible.

(k) Conducting meaningful medication reviews in consultation with pharmacy and nursing staff on a regular basis, with an interval between reviews of no more than six months.

(l) In the case of an unexpected death (including those resulting from an accident, whether recent or remote), notifying the Coroner of the circumstances of such death.

(m) In collaboration with the patient (or designate) along with the health care team participate in Advance Care Planning. Such planning should be completed and documented in a timely manner, preferably no later than the time of the admission care conference review. Thereafter it should be updated as clinically indicated and at least annually. Although having an advance directive cannot be mandatory as per s. 19.91 of the *Health Care (Consent) and Facilities(Admission) Act*, planning can and should still be discussed.

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(n) Should a discharge from a Facility occur, facilitating and coordinating such discharge to the community and ensuring communication with the primary-care Practitioner in the community, where present, as well as with community home support teams.

(o) Should a discharge occur, ensuring medication reconciliation and prescriptions are available upon discharge until the patient can be followed in the community.

(B) Most Responsible Practitioner for Care in Facilities

(1) Only Practitioners with appropriate Privileges may write orders and manage patients who require treatment in licensed residential care facilities operated by Island Health.

(2) These Practitioners are designated as the MRP and retain primary responsibility for all subsequent care ordered and carried out in the licensed Facility, whether or

not the MRP is physically present at the Facility.

(3) In exceptional circumstances, the CEO, through the Senior Medical Administrator (CMO), or designate may authorize a non-privileged Practitioner to order or provide care in a licensed Facility, as determined on a case-by-case basis.

(4)1.5.1.1 In any Island Health Facility with a contracted Medical Coordinator, the Medical Coordinator may provide certain direct care to residents without prior consultation with the MRP. Such care is limited to:

(a) Medication changes following a multidisciplinary care conference review, when the MRP has been invited and not been able to attend, and where there has been a consensus that such a change is in the best interest of the of patient. In such cases the patient or their substitute decision maker must have been included in the consensus.

(b) Referral for a psychiatric consultation where nursing staff and the Medical Coordinator deem it necessary for the ongoing care of the resident and/or the safety or protection of other residents or staff.

(c) Medical orders to comply with infection control requirements and the recommendations of the Medical Health Officer.

(d) Routine medical orders where the MRP has failed to respond to requests for care as required by these rules.

(e)(i) Urgent medical care where the MRP is not available or has failed to respond to requests for care.

(5) When care has been provided under any of the provisions in (4) above, the MRP shall be informed in due course either by telephone or in writing (via facsimile).

(C) Consultations, Shared Care and Transfer of Care:

(1) A consultation request should be made directly from the requesting Practitioner to the consultant. In the case of a consultant who visits the Facility on a regular basis, such request may be made through the care team with the approval of the MRP.

(2)1.5.1.1 A consultation is a request for a professional opinion in the management of a patient. Consultations may be on-site or off-site.

(3) In the case of on-site consultations that occur within an Island Health Facility, this must include a hands on evaluation of the patient, a review of all necessary documentation and the provision of a timely, dictated legible report in keeping with IHealth standards, giving both opinions and recommendations for management and/or treatment as well as the basis for that advice. The consultant will notify the requesting Practitioner on completion of the consultation as part of patient-centered care, either through direct

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communication or through the care team.

(4) In the case of an off site consultation occurring at the consultant's office documentation and communication shall comply fully with the guidelines set forth by the College of Physicians and Surgeons of BC.

(5)1.5.1.1 When available, a request for shared care with a nurse Practitioner may be made by the MRP. Such a request implies that there will be assistance in the management of a patient, with the expectation of continued co-management of patient care. This includes ongoing evaluation and assessment of the patient's condition and communication with the patient, family and other healthcare professionals by the nurse practitioner in the stead of the MRP. However on-going and regular communication between the nurse practitioner and the MRP is expected.

(6) A transfer of care request is a Practitioner to Practitioner request to transfer MRP status or other specific shared care responsibilities to another Practitioner. Practitioners making such a request are obligated to supply a summary report detailing the medical care plan for patient, as well as the projected care plan in place at the time of transfer. Transfer of care does not occur until the accepting Practitioner signifies acceptance in the patient record.

(D) Reports:

(1) All consultations, referral of care and transfer of care reports will follow best practice guidelines as determined by the Royal College of Physicians and Surgeons of Canada (RPSC) and the College of Family Physicians Canada (CFPC) and must meet or exceed the expectations of Island Health as identified in IHealth documentation standards. These reports are subject to practice audit to ensure compliance with documentation standards.

(2)(i) Copies of reports must respect patient privacy and confidentiality guidelines. Recipients to be copied must be identified in the body of the report.

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(E) Admission of Patients

1.5.1.1 The care of every patient shall be directed and authorized by an appropriately privileged Practitioner member who will hold primary responsibility for the care of the patient. This Practitioner shall be identified as the MRP.

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(F) Transfer of Patients

(1) The MRP should contact the Practitioner to whom he/she wishes to transfer care. The transfer of MRP status (other than "on-call") from one Practitioner to another shall be duly recorded on the Health Record.

(2) In those instances where a patient is transferred to another Facility the MRP, if not following the patient to the new location, shall ensure the transfer is completed in accordance with established policy and will contact the receiving Practitioner on request to provide information regarding the plan of care. A competent patient (or their representative) has the right to request a change of Practitioner. That Practitioner shall cooperate in transferring responsibility for care of that patient to another Practitioner with appropriate Privileges who is acceptable to the patient. If an acceptable Practitioner cannot be found by the treating Practitioner, the Facility Medical Coordinator may assist the patient in finding another Practitioner to agree to continue to provide care to the patient. If a willing Practitioner cannot be found, the appropriate EMD, or delegated Medical Director, will discuss options with the patient. Only upon provision of an alternate Practitioner may the current care provider cease care for the patient.

(G) Discharge of Patients

(1) The MRP (or delegate) shall provide a discharge order and complete the discharge summary in an approved modality for the EHR compliant with IHealth documentation policy, including communication about the course in the Facility, medications, follow-up plans, patient disposition and any advance care plans to the community Practitioners and healthcare professionals.

(2) A discharge summary is required for:

(a) All in-patient discharges regardless of length of stay

(b) All deaths; and

(3)1.5.1.1 To ensure continuity of care and patient safety, the discharge summary for those returning to the community should be completed at the time of discharge but must be completed within seven (7) days of discharge, with the expectation that Island Health will ensure the delivery of copies to appropriate recipients within two (2) days following completion.

Article 4 – Appendices

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4.11.5 Organ Donation and Retrieval

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Island Health and its Medical Staff will cooperate with the British Columbia Transplant Society in supporting the provincial program for organ donation and retrieval.

(A)1.5.1Membership and Appointment

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In cases where, under special or urgent circumstances, such as organ retrieval, temporary Medical Staff Privileges are required, the CEO may, in consultation with the Senior Medical Administrator, grant such appointments with specific conditions and for a designated purpose and period of time. These appointments must be ratified or terminated by the Board of Directors at its next meeting..

(B) Responsibility for Patient Care

(1) In the event of organ donation, responsibility for the maintenance of the physiological status of the organ donor may be transferred, at the discretion of the Most Responsible Practitioner, to a Practitioner member of the Organ Retrieval Team.

(2)1.5.1.1 Consent for organ and tissue donation shall be validated through the British Columbia Transplant Society Registry or obtained through the patient's next of kin in accordance with the Human Tissue Gift Act and Regulations.

(3)1.5.1.1 Organ donation, after the declaration of neurological death, permits the Most Responsible Practitioner to transfer to and/or share responsibility with the Organ Retrieval Team. Standard protocols available from the Organ Retrieval Team may be followed and orders may be given to a registered nurse or a respiratory therapist for the maintenance of the physiological status of the donor.

4.21.5 Delegation of a Medical Act

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(1) The delegation of a medical act to a registered member of a health profession defined under the Health Professions Act health professional other than another Practitioner may be appropriate in certain restricted circumstances in the interest of good patient care. Such delegation does not absolve the Practitioner of responsibility for the care of the patient but rather widens the circle of responsibility for the safe performance of the procedure. Responsibility is shared between the delegating Practitioner and the professional who performs the delegated act.

Commented [u2]: For my clarity, this means all who are under the Health Professions Act? Only those under the Health Professions Act?

This is an effort to make sure that only qualified persons who are subject to professional discipline can have a delegated medical act.. "Health Professional" is not a restricted term.

(2) The medical act must be clearly defined and circumscribed with the degree of

medical supervision indicated. The professional who will perform the delegated act must be in agreement. Competency requirements of individuals and the scope of practice of a professional group must be determined to decide what additional training is needed. A Practitioner with relevant expertise must ensure the required knowledge and skill are appropriately taught. A non-Practitioner may carry out the teaching, but not the examination for competence. Re-evaluation and, if necessary, re-training of all professionals who perform delegated medical acts should be carried out on a regular basis as required to maintain professional competency and an appropriate standard of care.

(3) The Board of Directors must approve all delegated medical acts before they can be performed within the Facilities and Programs of Island Health.

4.31.5 Scheduled Treatments and Procedures

This Article of the Rules refers to all scheduled medical, surgical and interventional treatments or procedures (hereinafter called "Procedure(s)") that require booking through Island Health booking services.

(A)1.5.1Booking Requirements

(1) Booking requests shall be requested by, or on behalf of, the Practitioner who has the authority to perform or request the procedure(s).

(2) Booking requests shall be submitted in accordance with approved Island Health booking request forms, processes and timelines.

(3) Required documentation, in accordance with established Island Health standards, shall be submitted at the time of the booking request.

(4) If scheduled treatments or Procedures are cancelled for administrative reasons, hospital staff shall be responsible for rebooking the procedure(s) in consultation with the Practitioner and for notification of the patient and the practitionerPractitioner.

(B)1.5.1Consent Requirements

Subject to applicable legislation, the Island Health health care consent policies and Procedures as well as applicable legislation will be followed at all times when obtaining and documenting consent for all electively scheduled procedure(s).

(1) For any individual not involved with care of the patient, patient consent is always required before observation of any procedure(s) is allowed.

(2) Requirements for Surgical Procedures:

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Commented [CT3]: Are not bookings submitted on behalf of the patient in patient centered care. I think this is a real issue as too often its is viewed as the practioner requesting resources when in reality it's the patient and that should engender more respect of the request

Commented [CT4]: Of the reasons for cancellation , aslo need some data reporting on this

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(a) A surgeon shall be the Most Responsible Practitioner for peri-operative management of the patient and for the performance of any surgical procedure.

(b) When surgery is performed by a Dentist, it is the responsibility of the Dentist to arrange coverage by an MRP with admitting Privileges to manage and coordinate the care of any inpatients. For outpatient or day surgery patients the Dentist may provide a history and physical from a medical Practitioner and the Dentist will act as MRP in these situations.

(c) Surgery will be performed with the assistance of a second health professional when so required by Island Health policy.

(d) The manager or supervisor of the operating room has the authority to cancel any procedure(s) if there are insufficient operational resources. The operation will be rescheduled in consultation with the Most Responsible Practitioner with the main considerations being the patient's interests and the optimum use of the operating room suite.

(e) Prior to the commencement of emergency procedure(s) in the operating room, a Practitioner must ensure documentation including a brief history, clinical status, and indication(s) for the procedure(s) has been performed.

(f) An anesthetic record must be completed prior to the patient leaving the operating room/post anesthetic recovery area.

(g) A post procedure note detailing any unusual circumstances related to the anesthetic shall be documented by the anesthetist (or delegate). This note must identify the specific Practitioners who require copies of the report.

(h) Before leaving the operating room, the surgeon shall ensure that the appropriate pathology requisition(s) for examination of tissues or other material has been completed, by the OR staff.

(i) The surgical record of operation must be completed within 24 hours of the procedure and will be transcribed by 7pm that day.

(j) Any patient deaths that occur in the operating room/post anesthetic recovery area must be reported to the Coroner at the time of death in accordance with the Coroners Act. All such cases shall be referred for review by the relevant quality and patient safety committee(s).

(k) Requirements for Non-Surgical Treatments/Procedures

Commented [CT5]: This is in conflict with the MRP rule section as a complex medical patient having a simple surgical procedure does not make sense except for the time the patient is in the OR. The concept of a procedure automatically conferring MRP status is flawed.

Commented [CT6]: Which takes priority?

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(l) On completion of non-surgical treatment(s) or procedure(s), the Practitioner shall document a progress note on the patient record, describing the treatment(s) or procedure(s), the outcome and any unusual circumstances.

(m) A post procedure note detailing any unusual circumstances related to incidents of clinical significance shall be documented by the Practitioner. This note must identify the specific Practitioners who require copies of the report.

4.4 PRONOUNCEMENT OF DEATH, AUTOPSY AND PATHOLOGY

(1) Only a Practitioner member of the Medical Staff may pronounce a neurological or unexpected death. Either a Practitioner member of the Medical Staff or qualified Practitioner may pronounce death in other circumstances.

(2) No autopsy shall be performed without an order of the Coroner or the written consent of the appropriate relative or legally authorized agent of the patient.

(3)1.5.1 In appropriate cases, the Most Responsible Practitioner shall make all reasonable efforts to obtain permission for the performance of an autopsy.

(4)1.5.1 All tissue or material of diagnostic value shall be sent to the Department of Pathology.

(5) Pathology specimens including body tissues, organs, material and foreign bodies shall not be released without due authorization of the Head of the Department of Laboratory Services or delegate.

(6) A Physician or nurse practitioner member of the Medical Staff shall complete the medical certificate of death or stillbirth.

(7) Deaths shall be reported to the Coroner in accordance with the requirements of the *Coroner's Act*.

4.5 REPORTING AND HOW TO GET HELP

(1) Island Health is a large and complex organization, and some types of incidents need to be reported so that organizational processes such as patient safety reviews can be properly and promptly initiated. In addition, Practitioners have a statutory obligation to report certain types of events, to the Regulatory Colleges.

(2) Patient safety concerns, emerging Incidents, and matters for occupational health & safety (ie: needlestick exposures) can be reported using the red button in the bottom right hand corner of the Intranet home page. Instructions are provided.

Commented [map9]: While there is no legislated requirement that a physician be the practitioner to pronounce death (as opposed to certification of death), are there any internal Island Health policies which place restrictions on who can do so?

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Commented [map10]: If nurse practitioners are members of the Medical Staff.

Commented [TSC11]: Super confused why this is located here and why it isn't connected to the earlier reporting section, or maybe it's supposed to be? Needs review and discussion.

(3) Concerns about most other types of issue (clinical care, ethical dilemmas, significant professional disagreements, etc.) should in the first instance be taken to your Division Head, or if necessary to your local Medical Lead, Medical Director, or Executive Medical Director. If you contact the wrong person they will be able to redirect you but it is most important not to delay reporting.

(4) Out of regular working hours, the organization always has an Administrator On-Call, Medical Director or Executive Medical Director on call to respond to urgent issues. One of these people will always have a clinical background. The Director (in the first instance) can be contacted via switchboard at any time.

(5) In the event of an argument or difficult situation arising with a member of Island Health staff, another Practitioner, student, patient or family member, or a situation where you feel threatened or could be perceived as threatening, you should:

(a) Take a deep breath and respectfully calm the situation if possible. If appropriate, apologize straight away – this does not expose you to legal risk, it reduces it. As soon as possible, calmly take yourself out of the physical situation.

(b) Tell local leadership what has happened.

(c) Write down what happened, in your own words, with the date and time. Keep this record, don't throw it away.

(6) Where working relations with a colleague become difficult over a period of time, you should try to resolve the difficulties with the colleague. If this does not work, ensure your Division Head is aware; if the difficulty is with your Division Head then you should bring this to your Department Head, Site Chiefs of Staff & Medical Directors. If you contact the wrong person they will be able to redirect you.

(7) Sometimes, an issue may not be directly related to work but might have an effect on your ability to perform. For the benefit of ourselves and our patients, it is important to recognize issues of emotional and/or health wellbeing and take steps to address them. Contacting your Division Head, colleague, friend, the Physician Health Program, or the CMPA is a great place to start.

(8) You can also seek advice and help with resolving conflicts from other senior colleagues, from the EMSS service (based in Medical and Academic Affairs), or from the Respectful Workplace specialist (based in Human Resources).

Commented [CT12]: This sounds like legal advice, should we get legal advice on providing legal advice?

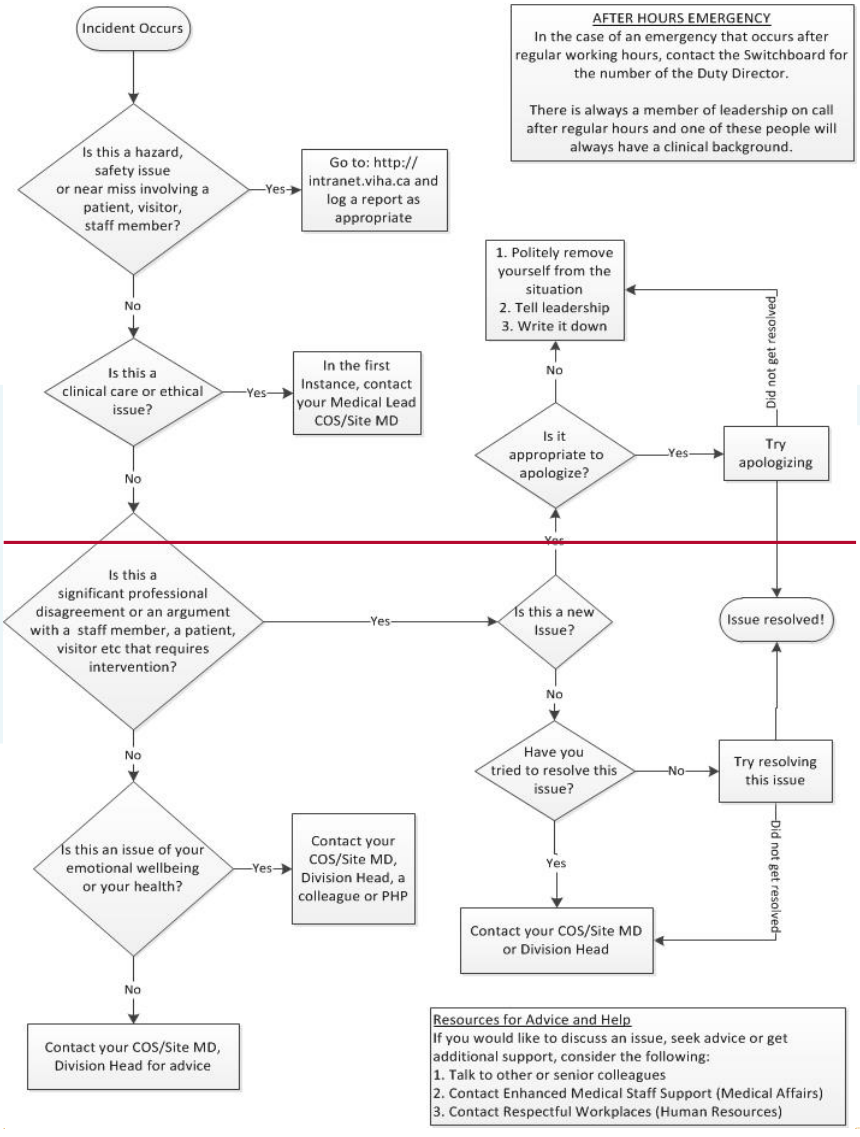
Commented [TSC13]: inapproriate

Commented [CT14]: What if its not a colleague

Commented [u15]: I don't think you mean CMA: CMPA? Physician Health?

Commented [TSC16]: News further review and discussion

Reporting and How to Get Help Flow Chart



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We would like to review and revise this chart.

For example: a significant professional disagreement or argument with a staff member can be a clinical care or ethical issue.

4.6 ~~Island Health Leadership Structures and Navigation~~

~~Island Health is Vancouver Island's largest employers with over 18,000 staff; it can be a challenge to find the right person to contact in an organization of this size. A Practitioner is always able to contact the Medical and Academic Affairs Department which acts as a central service for recruitment, credentialing, privileging, onboarding, performance process, governance, quality improvement, continuing professional development, contracting and remuneration of members of the Medical Staff of Island Health.~~

~~Practitioners should never hesitate to contact their Chief of Staff, Section, Division or Department Head for issues related to the Medical Staff or quality of care delivered at Island Health. Conversely, the Program side of Island Health has Medical Leads, Site Medical Directors, Medical Directors and Executive Medical Directors who can be called on for issues related to a patients' care.~~

~~Click here to view the Departmental Organization Structure~~

~~Click here to view the Programmatic Structure~~

~~Click here to view Island Health's Practitioner website~~

~~Click here to view Medical and Academic Affairs Contacts~~

~~4.7 MEDICAL UNDERGRADUATES AND POSTGRADUATES LEARNERS~~

~~(A)~~2.6.1 Undergraduate Learners

~~(1)~~2.6.1.1 Undergraduate learners include medical students ~~(UBC and visiting)~~ and midwifery students.

~~(2)~~2.6.1.2 In preparation for training at ~~Island Health~~VIHA students are required to complete specific onboarding requirements as mandated by both UBC and Island Health.

~~(3)~~2.6.2 Medical Students

~~(a)~~2.6.2.1 Must have an educational license from the College of Physicians and Surgeons of BC (CPSBC) in order to train in ~~Island Health~~VIHA Facilities and Programs.

~~(b)~~2.6.2.2 May participate in the care of patients under the direct supervision of a ~~member of the~~ Medical ~~-~~Staff~~, and/~~ member, or ~~indirectly~~ under the supervision of a Fellow or Resident ~~in the Department in which they are training~~ who is under direct supervision of the Medical ~~-~~Staff member.

~~(c)~~2.6.2.3 May perform Procedures under supervision of a Practitioner. They ~~must~~shall not be ~~required~~permitted to attempt Procedures ~~that~~ they are inadequately trained to perform or ~~Procedures~~those with any significant potential risk.

Commented [u18]: Also, should have a comment that they can contact the President or other Executive Member of the Medical Staff Association. Some are more comfortable with this as a first step, for advice, or for meeting with an administrator.

Although the MSA Exec are not part of "Island Health Leadership", they are part of the Island Health Medical Staff Leadership.

Commented [CT19]: I would think this avenue or DOBC should aslo be outlined where safety to report is not within the organization.

Commented [TSC20]: Review and revise to incorporate safe reporting and other options for reporting as mentioned in the comments

Commented [map21]:

This section is largely repetitive, covering the same ground covered above in the main body of the Rules. For consistency it would be preferable to address learners in one place.

Commented [TSC22]: Suggest all learner detail to appendix?

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~~(d)~~2.6.2.4 Must ensure that orders are discussed in advance with and countersigned by the supervising Practitioner, Fellow or resident ~~or Fellow~~.

~~(e)~~2.6.2.5 May not discharge, on their own, a patient from a ward in the hospital, from the Emergency Department, or the Outpatient Department. Patients can only be discharged once approval has been given by an attending Practitioner, Fellow or ~~a~~ resident.

~~(f)~~2.6.2.6 May not sign birth and death certificates, mental health certificates or other medico-~~-~~legal documents.

~~(g)~~2.6.2.7 May not sign prescriptions.

~~(h)~~2.6.2.8 May not dictate final versions of discharge summaries or consultation letters.

~~(i)~~2.6.2.9 Are expected to be on call, but must be directly supervised at all times.

~~(4)~~2.6.3 Midwifery students (UBC: Midwifery Policies and Procedures)

~~(a)~~2.6.3.1 May participate in the care of patients under the direct supervision of a Midwife member of the Medical Staff.

~~(b)~~2.6.3.2 Will complete clinical placements during years ~~-~~two, three and four under the supervision of a Midwife.

~~(c)~~2.6.3.3 Will attend antenatal or postnatal encounters. These include clinic, home and hospital ~~visits and is~~ in addition to intra-partum and perioperative care.

~~(d)~~2.6.3.4 May be responsible for chart entries during clinic or during a labour, birth or postpartum encounter. ~~It~~The student is ~~the student's responsibility~~responsible to ~~make sure~~ensure the appropriate registered Midwife signs off their ~~note(s).~~notes.

~~(e)~~2.6.3.5 Are expected to be on call.

~~(f)~~2.6.3.6 May attend Department meetings, practice meetings, educational forums, peer ~~-~~review sessions, phone consultations with clients and consultants, and prenatal classes.

~~(B)~~ ~~Postgraduate Learners:~~

2.6.4 ~~Postgraduate learners include Residents (UBC and visiting), Fellows and Trainees. All postgraduate learners must have an educational license (CPSID) from the College of Physicians and Surgeons of BC~~ (CPSBC: Postgraduate)

~~(1)~~2.6.4.1 Postgraduate learners include Residents, Fellows and Clinical Trainees. All postgraduate learners must have an educational license from the College of Physicians and Surgeons of BC in order to train in ~~Island Health~~VIHA Facilities and Programs~~(). .~~ In preparation for training at Island Health they are required to complete specific onboarding requirements as mandated by both UBC and Island

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Health.

~~**Dentistry Residents have not been included as part of this Article of the Rules as Island Health is not currently providing training for these learners.~~

~~(2) Residents (UBC: Resident Policies and Procedures)~~

2.6.5 Residents (UBC Resident Policies and Procedures)

~~(a)~~2.6.5.1 May participate in care of patients under the direct supervision of a member of the Medical Staff, ~~and/~~or ~~indirectly~~ under the supervision of a more senior Resident ~~in the Department in which they are training~~ who is under direct supervision of the Medical Staff member. **Formatted:** Heading 4

~~(b)~~2.6.5.2 May carry out such duties as ~~are~~ assigned ~~to them~~ by the supervising Medical Staff member ~~to whom they have been assigned~~.

~~(c)~~2.6.5.3 Must advise patients of their ~~status as a~~ trainee status.

~~(d)~~2.6.5.4 ~~Residents are to~~Shall notify ~~the~~their supervisor of their ~~assessment~~patient assessments and actions ~~with regard~~taken to ~~a patient~~provide care. Notification ~~implies~~requires direct contact and should be documented in the patient record.

~~(e)~~2.6.5.5 May not sign birth or death certificates and may not request autopsies.

~~(f)~~2.6.5.6 May not admit patients to a Facility except under the direction of a member of the Medical Staff.

~~(g)~~2.6.5.7 Are expected to participate in dictation requirements. All dictated notes must contain the supervising or ~~patient's attending Practitioners~~MRP Practitioner's name.

~~(h)~~2.6.5.8 May be allowed to prescribe any medications, including narcotics~~, but excluding methadone~~ under supervision. The name of the supervising Practitioner is to be printed on the prescription. ~~Note: Prescribing Privileges are not granted to visiting or elective Residents~~

~~(i)~~2.6.5.9 Are expected to be on call.

~~(i)~~2.6.5.10 Are expected to attend Departmental clinical conferences and rounds regularly. **Formatted:** Heading 4, Indent: Left: 0 cm

~~(3) Fellow~~

2.6.6 Fellows

~~(a)~~2.6.6.1 A Fellow is a post-graduate MD ~~trainee~~ pursuing further ~~postgraduate training~~ ~~(~~clinical or research training~~)~~ in ~~his/her~~a specialty or sub-specialty. Fellows have successfully ~~completed~~met all the ~~time and examination~~ requirements ~~that would allow them to be listed (registered) as a~~ for specialist licensure in their home country. **Formatted:** Heading 4

~~(b)~~2.6.6.2 A Fellow may participate in ~~Island Health~~ VIHA facilities under the following circumstances:

(i) ~~only if supported~~They are approved by the appropriate Department ~~and/~~or Division Head ~~concerned~~; and

(ii) ~~Recommended~~They are recommended by the ~~Medical Planning and Credentials Committee, the~~ HAMAC and approved by the Board of Directors~~; in which case they may:~~

2.6.6.3 Once approved, Fellows:

~~(a)~~ (i) may attend patients under the supervision of a member of the Medical Staff of the Department responsible for their supervision ~~of their work in the hospital~~;

~~(b)~~ (ii) may carry out such duties as are assigned to them by the Department Head or delegate to whom they have been assigned;

~~(c)~~ (iii) may not admit patients under their name; and

~~(d)~~ (iv) may not vote at Medical Staff or Department meetings.

2.6.7 Medical Staff Preceptors and Supervisors:

2.6.7.1 The UBC affiliation agreement stipulates that the Faculty of Medicine shall provide suitable appointments to the University for those Medical-Staff members who are involved in teaching programs of the University, subject to the University's policies and procedures.

2.6.7.2 To be involved in the teaching of UBC medical students and residents, Practitioners shall apply for and maintain an appointment with the UBC Faculty of Medicine.

2.6.7.3 All Medical-Staff members are expected to participate in teaching as a condition of their appointment.

2.6.7.4 Medical-Staff members are not responsible for onboarding or verifying that learners have met all the onboarding requirements as mandated by UBC and VIHA.

2.6.7.5 Practitioners involved in teaching activities are responsible for ensuring that all learners are engaging in activities appropriate to their level of training. Learners are not to be placed in situations that may compromise safety.

2.6.7.6 Medical-Staff members must advise patients or their designates when residents or students may be involved in their care and obtain consent for such participation.

2.6.7.7 Supervisors and preceptors must be available by phone or pager, when not available in person, to respond in a timely manner and be available to attend to the patient in an emergency. When not immediately available, they must ensure that an appropriate alternate Medical-Staff member is available and has agreed to provide supervision.

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2.6.7.8 Supervisors and preceptors shall assess, review and document trainee competence in accordance with UBC policies.

2.6.8 Research

2.6.8.1 VIHA views research as a core component of its mandate and encourages Medical Staff to contribute to the generation and application of evidence that will improve the quality of care provided. The requirements and resources available for conducting research in VIHA are as follows:

(i) Individuals conducting research at Island Health must comply with Policy 25.3 Research Integrity, as well as any other applicable VIHA research policies and procedures.

(ii) Research conducted at VIHA requires VIHA Research Ethics approval.

(iii) Approval must be obtained from all VIHA Department(s) involved in the support or conduct of the research project.

(iv) Individuals conducting clinical research at VIHA, including interventions involving human research participants, must be trained in Good Clinical Practice (GCP) as defined by the International Council on Harmonization (ICH).

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3 Residential Facilities Operating under the Hospital Act

VIHA operates a number of residential care facilities under Part 2 of the *Hospital Act*. The VIHA Medical Staff Rules apply to practitioners providing care in VIHA-operated residential-care facilities. This section highlights unique rules that guide the care of patients in these facilities.

3.1 Most Responsible Practitioner (MRP)

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3.1.1.1 The care of every resident shall be directed and authorized by an appropriately-privileged Practitioner who will hold primary responsibility for the care of the patient. This Practitioner shall be identified as the MRP.

3.1.1.2 MRPs are identified as Practitioners who agree to accept patients within a residential care Facility under their medical direction. The MRP may be determined either prior to, or at the time of, admission.

3.1.1.3 The MRP is a shared-care role in delivery of health and treatment services to patients. The MRP is the Practitioner responsible for directing and coordinating the care of a patient admitted to a Facility. However, in urgent situations where the MRP is not immediately available other duly-qualified Practitioners may provide immediate care to patients. The MRP shall be informed subsequently of such care.

3.1.1.4 During a patient's Facility stay, the role of the MRP may be transferred, as outlined below.

The MRP:

(i) Admits or accepts patients from acute care sites, other Facilities, the community or from another Practitioner;
(ii) Reviews documentation and augments it as required to ensure that a full medical assessment is completed, including admission and continuing-care orders;
(iii) Works collaboratively with pharmacists and nurses to complete a Best Possible Medication History (BPMH) and orders appropriate medications. Discharge orders from acute-care Facilities shall be considered valid for up to seven (7) days, pending confirmation by the MRP;
(iv) Provides periodic care, completes progress notes and oversees the patient's care in the Facility, either directly or through an on-call group;
(v) Communicates with the resident, their next of kin and legally-appointed Representative regarding medical conditions, any tests or consultations planned, and the results of such tests or consultations;
(vi) Works collaboratively with healthcare team members;
(vii) When necessary, resolves apparent treatment or management conflicts among shared-care providers;

(viii) Attends each newly admitted resident or resident readmitted from acute care to assess, conduct a review of documents and confirm admission orders within seven (7) days of admission or re-admission;

(ix) Proactively visits each resident with an interval between visits of no more than 90 days;

(x) Attends annual multi-disciplinary care conference reviews whenever possible;

(xi) Conducts meaningful medication reviews in consultation with pharmacy and nursing staff on a regular basis, with an interval between reviews of no more than six months;

(xii) In the case of an unexpected death (including those resulting from an accident, whether recent or remote), notifies the Coroner of the circumstances of such death;

(xiii) In collaboration with the resident (or designate) along with the health care team, participates in Advance Care Planning. Such planning should be completed and documented in a timely manner, preferably no later than the time of the admission care-conference review. Thereafter it should be updated as clinically indicated and at least annually. Although having an advance directive cannot be mandatory as per s. 19.91 of the *Health Care (Consent) and Facilities(Admission) Act*, planning can and should still be discussed;

(xiv) Should a discharge from a Facility occur, the MRP facilitates and coordinates the discharge to the community and ensures communication with the primary-care Practitioner in the community, where present, as well as with community home-support teams; and

(xv) Should a discharge occur, ensure medication reconciliation and prescriptions are available upon discharge until the patient can be followed in the community.

3.1.2 Most Responsible Practitioner for Residential Care Facilities

3.1.2.1 Only Practitioners with appropriate Privileges may write orders and manage residents who require treatment in licensed residential care facilities operated by Island Health.

3.1.2.2 These Practitioners are designated as MRP and retain primary responsibility for all subsequent care ordered and carried out in the licensed Facility, whether or not the MRP is physically present at the Facility.

3.1.2.3 In exceptional circumstances, the CEO, through the CMO, or designate, may authorize a non-privileged Practitioner to order or provide care in a licensed Facility, as determined on a case-by-case basis.

3.1.2.4 In any Island Health Facility with a contracted Medical Coordinator, the Medical Coordinator may provide direct care to residents without prior consultation with the

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MRP. Such care is limited to:

(i) Medication changes, following a multidisciplinary care conference review, when the MRP has been invited and not been able to attend and where there is a consensus that the change is in the best interest of the resident. In such cases the resident or their substitute decision maker must have been included in reaching consensus;

(ii) Referral for a psychiatric consultation where nursing staff and the Medical Coordinator deem it necessary for the ongoing care of the resident or the safety and protection of other residents or staff;

(iii) Medical orders to comply with infection-control requirements or recommendations of the Medical Health Officer;

(iv) Routine medical orders where the MRP has failed to respond to requests for care; and

(v) Urgent medical care where the MRP is not available or has failed to respond to requests for care.

(1) When care has been provided based on any provisions in article 3.5.2.4 above, the MRP shall be informed in due course either by telephone or in writing (via written order on the chart, facsimile, or by entry in an EHR if implemented at the site).

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3.1.3 Consultations, Shared Care and Transfer of Care

3.1.3.1 A consultation request should be made directly from the requesting Practitioner to the consultant. In the case of a consultant who visits the Facility on a regular basis, the request may be made through the care team with the approval of the MRP.

3.1.3.2 A consultation is a request for a professional opinion in the management of a patient. Consultations may be on-site or off-site.

3.1.3.3 An on-site consultation must include an in-person evaluation of the patient, a review of all necessary documentation and the provision of a timely, dictated or legible written report in keeping with IHealth standards. It shall include both opinions and recommendations for management and treatment, as well as the basis for that advice. The consultant will notify the requesting Practitioner on completion of the consultation, either through direct communication or through the care team.

3.1.3.4 In the case of an off-site consultation at the consultant's office, documentation and communication shall comply with the guidelines set forth by the College of Physicians and Surgeons of BC.

3.1.3.5 When available, the MRP may make a request for shared care with a nurse Practitioner. This request implies assistance with management of the resident, with the expectation of ongoing co-management. This includes regular evaluation and assessment of the resident's condition and communication with the resident, family

and other healthcare professionals by the nurse practitioner. On-going and regular communication between the nurse practitioner and the MRP is expected.

3.1.3.6 A transfer-of-care request is a Practitioner-to-Practitioner request to transfer MRP status or other specific shared-care responsibilities to another Practitioner. Practitioners making such a request shall supply a summary report detailing the medical care plan for the resident in place at the time of transfer. The transfer of MRP status (other than "on-call") from one Practitioner to another shall be duly recorded on the Health Record. Transfer-of-care does not occur until the accepting Practitioner documents acceptance in the patient record.

3.1.3.7 In those instances where a resident is transferred to another Facility the MRP, if not resuming care at the new location, shall ensure the transfer is completed in accordance with established policy and shall contact the receiving Practitioner to provide information regarding the plan of care and complete a discharge summary.

3.1.4 Reports

3.1.4.1 All consultations, referrals-of-care and transfers-of-care reports shall follow best-practice guidelines of the Royal College of Physicians and Surgeons of Canada (RPSC) and the College of Family Physicians of Canada (CFPC), and must meet or exceed the expectations of Island Health as identified in IHealth documentation standards. These reports are subject to practice audit to ensure compliance with standards.

3.1.4.2 Copies of reports must respect patient privacy and confidentiality guidelines. Recipients to be copied must be identified in the body of the report.

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3.1.5 Discharge of Residents

3.1.5.1 The MRP (or delegate) shall provide a discharge order and complete the discharge summary in compliance with IHealth documentation policy, including communication about the course in the Facility, medications, follow-up plans, resident disposition and any advance care plans to the community Practitioners and healthcare professionals.

3.1.5.2 A discharge summary is required for:

(i) All resident discharges regardless of length of stay; and
(ii) All deaths.

3.1.5.3 To ensure continuity of care and patient safety, the discharge summary for residents returning to the community should be completed at the time of discharge but must be completed within seven (7) days of discharge, with the expectation that Island Health will ensure the delivery of copies to appropriate recipients within two (2) days following completion.

4 Regulated Provision of Care

4.1 Organ Donation and Retrieval

VIHA and its Medical Staff shall cooperate with the British Columbia Transplant Society in supporting the provincial program for organ donation and retrieval.

4.1.1 Membership and Appointment

4.1.1.1 In cases where, under special or urgent circumstances, such as organ retrieval, temporary Medical Staff Privileges are required, the CEO may, in consultation with the Senior Medical Administrator, grant such appointments with specific conditions and for a designated purpose and period of time. These appointments must be ratified or terminated by the Board of Directors at its next meeting.

4.1.2 Responsibility for Patient Care

4.1.2.1 In the event of organ donation, responsibility for the maintenance of the physiological status of the organ donor may be transferred, at the discretion of the Most Responsible Practitioner, to a physician member of the Organ Retrieval Team.

4.1.2.2 Consent for organ and tissue donation shall be validated through the British Columbia Transplant Society Registry or obtained through the patient's next of kin in accordance with the Human Tissue Gift Act and Regulations.

4.1.2.3 Organ donation, after the declaration of neurological death, permits the Most Responsible Practitioner to transfer to or share responsibility with the Organ Retrieval Team. Standard protocols available from the Organ Retrieval Team may be followed and orders may be given to a registered nurse or a respiratory therapist for the maintenance of the physiological status of the donor.

4.2 Delegation of a Medical Act

4.2.1 The delegation of a medical act to a registered member of another health profession defined under the Health Professions Act may be appropriate in certain restricted circumstances. Such delegation does not absolve the Medical Staff member of responsibility for the care of the patient but rather widens the circle of responsibility for the safe performance of the procedure. Responsibility is shared between the delegating Practitioner and the person who performs the delegated act.

4.2.2 The delegated medical act must be clearly defined and circumscribed by the degree of medical supervision required. The person to perform the act must agree to the delegation. Competency requirements of individuals and the scope of practice of a

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professional group must be determined to decide what additional training is needed. A Practitioner with relevant expertise must ensure the required knowledge and skill are taught appropriately. A non- Medical-Staff practitioner may carry out the teaching, but not the examination for competence. Re-evaluation and, if necessary, re-training of all professionals who perform delegated medical acts should be conducted on a regular basis as required to maintain professional competency and an acceptable standard of care.

4.2.3 The Board of Directors, on the advice of the HAMAC, must approve all delegated medical acts before they can be performed within VIHA Facilities and Programs.

4.3 Scheduled Treatments and Procedures

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This Article refers to all scheduled medical, surgical and interventional treatments or procedures (hereinafter called "Procedure(s)") that are scheduled through VIHA booking services.

4.3.1 Booking Requirements

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4.3.1.1 Booking requests shall be requested on behalf of the patient by the Practitioner or delegate who has the authority to perform or request the procedure(s).

4.3.1.2 Booking requests shall be submitted in accordance with approved VIHA booking request forms, processes and timelines.

4.3.1.3 Required documentation, in accordance with established VIHA standards, shall be submitted at the time of the booking request.

4.3.1.4 If scheduled treatments or Procedures are cancelled for administrative reasons, VIHA staff shall be responsible for rebooking the procedure(s) in consultation with the Practitioner and for notification of both the patient and the Practitioner, including the reason(s) for the cancellation.

4.3.2 Consent Requirements

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4.3.2.1 VIHA consent policies and procedures as well as applicable legislation shall be followed at all times when obtaining and documenting consent for all electively scheduled procedures.

4.3.2.2 For any individual not involved in the care of the patient, patient consent is always required before observation of any procedure(s) is allowed.

4.3.3 Requirements for Surgical Procedures

4.3.3.1 A surgeon shall be the Most Responsible Practitioner for peri-operative management of the patient and for the performance of any surgical procedure.

4.3.3.2 When surgery performed by a Dentist will result in hospital admission, the Dentist is responsible to arrange admission by a Medical-Staff member with admitting Privileges. For outpatient or day surgery, the Dentist may provide a written or electronic history and physical exam from a medical Practitioner. The Dentist will act as MRP in these situations.

4.3.3.3 Surgery shall only be performed with the assistance of a second Medical-Staff member where VIHA policy so requires.

4.3.3.4 The manager or supervisor of the operating room may cancel any procedure(s) if there are insufficient resources or staff to proceed. The operation shall be rescheduled in consultation with the MRP based on the primary considerations of the patient's well-being and the optimum management of the operating room facilities.

4.3.3.5 Prior to the commencement of any emergency surgery or procedure in the operating room, a Medical Staff member must ensure written or electronic documentation is available, including a brief history and physical exam, the patient's clinical status, and indication for the procedure to be performed.

4.3.3.6 An anesthetic record must be completed before the patient leaves the operating room or post-anesthetic recovery area.

4.3.3.7 The anesthesiologist or delegate shall document any unusual circumstances related to the anesthetic or post-anesthetic recovery and specify those Practitioners who require copies of the documentation.

4.3.3.8 Before leaving the operating room, the surgeon shall ensure that the required pathology requisitions have been completed by the OR staff.

4.3.3.9 The surgical record of operation must be dictated or written within 24 hours of the procedure, but preferably immediately post-procedure.

4.3.3.10 In compliance with the Coroners Act, any patient deaths that occur in the operating room or post anesthetic recovery area must be reported to the Coroner at the time of death. All such cases shall be referred to the Surgical Quality Council for review.

4.3.4 Requirements for Non-Surgical Treatments and Procedures

4.3.4.1 On completion of a non-surgical treatment or procedure the Practitioner shall document a progress note on the patient record, describing the treatment or procedure , and the outcome. This note shall include any unusual circumstances or incidents of clinical significance related to the treatment or procedure. This note must identify those Practitioners who require copies of the report.

4.4 Pronouncement of Death, Autopsy and Pathology

4.4.1 VIHA policy governs those personnel who may pronounce an expected death. Only a member of the Medical Staff may pronounce a neurological or unexpected death. Only a physician or nurse-practitioner member of the medical staff may provide certification of death or stillbirth.

4.4.2 No autopsy shall be performed without a Coroner's order or the written consent of the appropriate relative or legally-authorized agent of the patient.

4.4.3 In appropriate cases, the Most Responsible Practitioner shall make all reasonable efforts to obtain permission for the performance of an autopsy.

4.4.4 All tissue or material of diagnostic value shall be sent to the Department of Pathology.

4.4.5 Pathology specimens including body tissues, organs, material and foreign bodies shall not be released without due authorization by the Head of the Department of Laboratory Services or delegate.

4.4.6 Where the manner of death meets reporting requirements outlined in the *Coroner's Act,* the death must be reported to the Coroner.

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4.7 Reporting & Managing Unprofessional Behaviour

4.7.1 Purpose

~~(4) Trainees~~

~~Trainees are post-MD Trainees pursuing further postgraduate training (clinical or research training) in his/her specialty or sub-specialty. A trainee has completed the time requirements but not the examination requirements; and, therefore does not meet the following fellowship eligibility criteria. (CPSBC: Class of Registration; UBC: Prospective Trainees)~~

~~(5) Practitioner in Supervised Practice~~

~~Under Development~~

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4.7.1.1 To encourage the prompt identification and management of behaviour that is contrary to the VIHA Respectful Workplace Policy or the Code of Ethics of a practitioner's professional regulatory body, which may adversely affect the delivery of safe patient care in any facility operated by VIHA, and;

4.7.1.2 To provide transparent processes to manage unprofessional behaviour by members of the Medical Staff, including those in leadership positions.

~~4.8~~4.7.2 Principles ~~of Partnership Governing Professionalism~~

4.7.2.1 Breach of standard for professional or respectful behaviour will be addressed in a consistent, equitable and timely manner.

4.7.2.2 All reports of unprofessional behaviour, received verbally or in writing, will be considered carefully and addressed.

4.7.2.3 Where perceived unprofessional behaviour is observed or experienced in a VIHA Facility, it should be reported to a Division Head, Department Head, or Site Chief of Staff. The medical leader who first receives such a report is responsible to ensure it is investigated and followed up in a timely manner.

4.7.2.4 Where perceived unprofessional behaviour involves a medical leader, it should be reported directly to the CMO or designate. If a perceived lack of psychological or physical safety exists, Medical Staff may report concerns to the CEO through the process outlined in the VIHA Safe Reporting Policy . The Safe Reporting Policy provides that a review of the conduct of any person associated with VIHA, including a member of the Medical Staff, may be initiated through the VIHA Safe Reporting Officer or General Counsel. The Safe Reporting Policy does not replace established procedures for managing unprofessional conduct as set out herein.

4.7.2.5 Reports of unprofessional behaviour will be investigated as soon as possible, usually within two to four weeks.

4.7.2.6 Retaliation of any kind against a reporter of unprofessional behaviour is expressly forbidden and will result in disciplinary action against the perpetrator.

4.7.2.7 The review of a serious allegation involving a member of the Medical Staff shall be conducted in consultation with the CMO's Office. In cases where the cancellation, suspension, restriction or non-renewal of Privileges may be warranted, the matter shall be referred to the HAMAC, who shall make recommendations to the Board and CEO in accordance with Article 12 of the Bylaws.

4.7.3 Managing Unprofessional Behaviour

4.7.3.1 Unprofessional behaviour is not tolerated in Island Health. Management of this behaviour requires a transparent investigative, evaluative and reporting system, known to the practitioner from the outset and supporting a culture of just

Commented [u25]: Partnership requires two to agree.

The problem that I have with this is that it is the product of a committee which is addressing a personnel problem, which should be addressed by other means.By including e.g. (2) and (3), it assumes that MOST of the medical staff are rotten schoolboys whose mothers should have washed their mourths out with soap, or otherwise taught them manners. Some are, but not all. Behavioural requirments of Island Healath are better dealt with thru the on-boarding (horrible neologism) process, than annually have to say "I won't make sexually inappropriate comments this year." Rather like answering the question of are you still beating your wife?

The changes that I have made are more consistent with a culture of a "compact", with both sides making similar commitments.

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application of consequence. Detailed processes to support the fair and timely management of unprofessional behaviour are identified in Article 4.8 of these Rules.

4.7.4 Managing Issues of Clinical Competence

4.7.4.1 Oversight of professional competence includes professionalism, judgement, and performance to expected standards within the Department. Assessment of competence is much more than the evaluation of technical skill.

4.7.4.2 Concerns arising from clinical practice which suggest possible deficiencies of competence are a key obligation of Medical Staff Leadership to both monitor and address. Due process in the means of assessing and evaluating competence are described in Article 4.8 of these Rules.

4.7.5 Whistle Blowing Policy

4.7.5.1 Island Health expects all Practitioners to report suspected wrongdoing through appropriate administrative channels. Alternately, individuals may report suspected wrongdoing to the Designated Central Point of Contact (DCPC) as defined within the VIHA Whistle Blower policy, or the independent-third-party reporting service.

4.7.5.2 Reports under this policy must be made in good faith and based on reasonable grounds.

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~~**Introduction**~~

~~Island Health and _____ [insert name of Medical Staff member] recognize their considerable interdependence in the rapidly changing healthcare environment. The provision of high quality, cost-effective healthcare depends in large part upon the ability of all members of the Health Care Team to develop trust, communicate well, collaborate effectively, be mutually supportive, and work effectively as part of a team.~~

~~Striving for quality can lead to a difference in opinion. However, the expectation is that these disagreements be carried out in a professional and non-personalized manner.~~

~~**Principles**~~

~~In order to accomplish these goals, I agree to the following principles and guidelines and to work collaboratively to promote them in the organization and in the community.~~

Commented [u26]: Island Health and _____ jointly agree

~~**1) Respectful Treatment**~~

~~In my work, I agree to treat all persons in a respectful, dignified manner at all times. This particularly pertains to members of the healthcare provider team and all direct and indirect recipients of healthcare (patients, their families, visitors). I recognize that concerns regarding interdisciplinay team performance must be taken through appropriate channels, where possible.~~

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~~**2) Language**~~

Island Health requires the use of respectful language at all times. Verbal, written and electronic communication, including chart notes, correspondence and other documents, will be respectful and professional in language and tone. This will apply in all my dealings with colleagues, other members of the medical staff, other clinicians and all employees of Island Health, in whatever position. Island Health will ensure my psychological safety and freedom to practice free of disrespectful behavior.

3) Behavior

I agree to behave respectfully toward others at all times, and to refrain from any behavior that is disrespectful, profane, vulgar, intimidating, demeaning, harassing, humiliating, or sexually inappropriate. This includes but is not limited to: obscene gestures, violation of reasonable personal space, yelling, throwing of objects, menacing gestures, unwanted or sexual touching, degrading or sexually oriented jokes or comments, or requests for personal or sexual favors. It also includes making inappropriate comments regarding other practitioners, hospital employees, other providers, or patients.

Island Health administrators, both medical and non-medical, will ensure that I am not subjected to any administrative bullying nor to any behavior that is disrespectful, profane, vulgar, intimidating, demeaning, harassing, humiliating, or sexually inappropriate. This includes but is not limited to: obscene gestures, violation of reasonable personal space, yelling, throwing of objects, menacing gestures, unwanted or sexual touching, degrading or sexually oriented jokes or comments, or requests for personal or sexual favors. It also includes making inappropriate comments regarding other practitionersPractitioners, hospital employees, other providers, or patient care provided by myself or others.

4) Confidentiality and Privacy

I agree to maintain complete confidentiality of patient care information at all times, in a manner consistent with generally accepted principles of medical confidentiality. I recognize that Practitioners and hospital staff have the right to have personal or performance problems and concerns about competence discussed in a confidential manner in a private setting, governed by the underlying principles of *need to know*. I agree to maintain this confidentiality and to seek proper, professional, objective arenas in which to deal with these issues.

5) Advocacy

I agree that Practitioners are in an ideal position to identify areas for change and to recommend improvements within the heath authority. The role of advocate is an integral function to ensuring quality and innovation in healthcare. I recognize the role of advocate individually and collectively for patients and agree that efforts to ensure the delivery of quality of care will not be obstructed by the role of advocate, but rather be strengthened by it.

Island Health agrees to support me in this role.

6) Responsible Work Practice and Resources

As part of responsible work practice, I agree to be available to respond to calls as deemed appropriate to maintaining good quality of patient care. I agree to notify appropriate personnel if unable to attend work. I agree to participate in Departmental, Divisional and medical association activities.

While recognizing that the total financial resources available to Island Health are not under Island Health's control, Island Health will make every effort to ensure that the resources are necessary for

safe and responsible work, and that they are used in the most clinically efficient and responsible manner.

Support for Quality of Care I recognize the organizational structures which support Island Health facilities to operate smoothly, effectively and efficiently. Interdisciplinary Team, as a member of Medical Staff who holds Privileges regardless of clinical or administrative, recognize the requirement for quality and performance reviews. I agree to engage other parties in constructive and timely dialogue and to work collaboratively to address these issues.

Similarly, Island Health recognizes the requirement for quality and performance reviews of its programs and the way they are organized, and will engage with me, as well as other parties in constructive and timely dialogue and work collaboratively to address these issues. Island Health will not hold confidential or secret the results of such program performance reviews, but shall share them with all involved Departments and practitioners.

7) Supporting Rules and Regulations

I recognize the need for certain rules and regulations for all to follow, in order to assure the smooth, harmonious, and safe functioning of Island Health facilities, both clinically and otherwise. I agree to abide by these regulations, including those that relate to safety, scheduling, confidentiality, documentation, and the like. I agree to be familiar with, and abide by, the Medical Staff Bylaws, Rules and associated policies and regulations.

8) No Retribution

I agree not to engage in any behavior that could reasonably be considered retributive, such as: making implied or direct threats, physically intimidating behavior, withholding information, refusing to speak to coworkers, or attempting to find out who might have registered a complaint.

Island Health will not engage in any behavior that could reasonably be considered retributive to whistleblowing or advocacy activites with the exception of those processes outlined in Section 1.6 of the Medical Staff Rules.

The foregoing Principles of Partnership are acknowledged and agreed to this ____ day of _____, 20___ by:

_____

Name: [Insert name of Medical Staff member]

Chief Medical Officer, or Executive Medical Director.

~~APPENDIX C...~~

~~(A)~~4.8 MANAGING UNPROFESSIONAL BEHAVIOUR OR FAILURE TO MEET STANDARDS OF CARE: OVERVIEW OF PROCESS

At all stages of this process, the medical leader must investigate the complaint and determine its seriousness and impact. Based on these findings, an assignment of the appropriate stage of intervention, outlined below, will be confirmed. If the physician whose behaviour or care is felt to be inappropriate is a medical leader, the issue will be escalated to the medical leader to whom that physician reports.

4.8.1 Interventions have the goal of remediation and will generally follow a staged approach ~~with the goal of remediation~~, outlined below:

~~(a) Stage Zero: first time incidents of unprofessionalism that are perceived as being of low severity.~~

~~(b) Stage One: incidents of unprofessionalism that are of moderate severity or where Stage Zero intervention has been ineffective.~~

~~(c) Stage Two: ongoing unprofessional behaviour which has continued despite previous intervention. Documentation of this stage remains on the record in the Medical Staff member's file. Appeals to this can be made to the **Disciplinary? Committee**. This documentation will be securely maintained within a Department Head office and by EMSS. [**NTD:** We need to discuss this. We should be documenting Stage Zero, Stage One to be able to confirm the legitimacy of Stage Two.]~~

4.8.1.1 ~~Stage Three: ongoing unprofessional behaviour that has continued despite Stage One and Stage Two intervention and/or incidents of unprofessional behaviour which present~~Stage Zero: This stage of intervention refers to discussions between medical staff members regarding minor incidents involving either behaviour or clinical care. These discussions may occur between the medical practitioner and the person who has the concern, or may involve the local medical leader at the request of that person. The medical staff member or medical leader believes the issue can be resolved by a casual conversation with the medical staff member under discussion. If the individuals involved resolve their conflict mutually, then no further intervention is necessary. Otherwise a Stage 1 intervention is warranted. Although documentation is at the discretion of the person addressing the incident, medical leaders are encouraged to record the subject, date, time and location of the conversation in the confidential medical staff database managed by EMSS. An email or memo thanking the physician for the discussion is often an effective way of doing this.

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4.8.1.2 Stage One: This stage is warranted for first-time behaviours or questionable clinical practice that is perceived to be significant or where Stage Zero intervention has been ineffective. The Division Head, Department Head, or Chief of Staff will formally meet with the medical staff member. During the meeting, the medical leader will describe the incident as reported, seek a response from the member, ensure that the member understands how others have interpreted the behaviour or clinical decision, consider mitigating factors and identify the corrective action(s) needed to resolve the issue. The medical leader is required to document the content of the meeting, decisions that were reached regarding corrective action(s), schedule for follow-up meetings, and potential consequences if the identified behaviour or questionable practice continues. Failure to comply with such recommendation is grounds for escalation. The medical leader shall provide a copy of the documentation to the medical staff member and forward a copy to EMSS for storage in the confidential medical staff database. A template for documentation will be provided by EMSS to the medical leader.

4.8.1.3 Stage 2: This stage of intervention is warranted for behaviour that is of greater severity or where a Stage 1 intervention has been ineffective. It also applies to known aberrancy from accepted clinical practice or where professional judgment/actions risk patient well-being or safety. The Division Head, Department Head, or Chief of Staff shall inform Medical-Staff-Governance Executive Medical Director (EMD). The EMD in collaboration with the Department Head and Chief of Staff will follow the same process as in Stage 1, and will develop a contract between the member and Medical Affairs that includes methods of remediation and redress, which may include but not be limited to voluntary changes in practice, supervision of aspects of practice by another member of medical staff, specific educational or behavioural interventions and internal or external in depth review. The EMD will notify the member that another incident may result in a review by HAMAC. Failure to comply with such recommendation is grounds for escalation including, depending upon the nature of the issue, summary suspension of privileges and referral to HAMAC. The medical leader shall provide a copy of the documentation to the medical staff member and forward a copy to EMSS for storage in the confidential medical staff database. A template for documentation will be provided by EMSS to the medical leader.

~~(d)~~4.8.1.4 Stage 3: This stage of intervention is required for behaviour or questionable practice that has continued despite previous interventions, or that presents a serious or potentially-serious problem ~~or potential problem which~~that adversely affects, or may adversely affect, the care of patients, or the safety and security of patients or staff ~~but~~. Stage 3 interventions occur if the situation does not require

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immediate ~~action~~suspension to protect the safety and best interests of patients or staff. The Department Head together with the Chief of Staff or Medical Staff Governance EMD will inform the Chief Medical Officer and the Chair of HAMAC. The office of the Chief Medical Officer is responsible to manage Stage 3 investigations. The medical leader shall provide a copy of the documentation to the medical staff member and a copy to EMSS for storage in the confidential medical staff database. A template for documentation will be provided by EMSS to the medical leader.

~~Stage Four/~~

~~(e)~~4.8.1.5 Crisis Intervention: ~~the~~The sudden appearance of behaviour that is too egregious for a staged response ~~and/~~, or where a serious problem or potential problem ~~which~~ adversely affects or may adversely affect ~~the~~patient care ~~of patients,~~ or the safety and security of patients or staff and immediate action is required ~~to protect the safety and best interests of patients or staff. Such~~. These situations will be addressed in accordance with Article 11 of the Bylaws. ~~**[NTD: Discussion of retention of records required.]**~~

4.8.2 Uniform Approach for Managing Unprofessional Behaviour~~: Documentation~~

4.8.2.1 Documentation of Stage One, Two, Three and Crisis Interventions shall remain in the Medical Staff member's file permanently. This documentation will be securely maintained within the EMSS office.

4.8.2.2 If at any stage of intervention, the Medical Staff member disputes the reported behaviour, disagrees that the behaviour complained of was unprofessional, or the parties are unable to resolve the complaint, the complaint may be referred to the LMAC or the Discipline Subcommittee of the HAMAC for further investigation.

4.8.2.3 Any retributive behaviour by a Medical Staff member against a complainant shall result in immediate escalation of the disciplinary process.

~~(B)~~ Managing Unprofessional Behaviour or Failure to Meet Standards

~~(1) Having met with the subject of the complaint, for those concerns warranting further intervention or investigation, the Department Head, Division Head, Chief of Staff/Site Medical Director with the aid of EMSS will document (the "Stage Summary"):~~

~~(i) the original complaint and/or description of the behaviour;~~

~~(ii) the discussion with the Medical Staff member, including the Medical Staff member's comments or position regarding the complaint;~~

~~(iii) any mitigating factors that have been considered;~~

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~~(iv) specific resources offered or mandated as part of any remediation or otherwise;~~

~~(v) reports from other professionals (therapists, coaches, mentors etc.), if applicable, who have been engaged as part of any remediation; and~~

~~(vi) confirmation that the consequences of continued unprofessional behaviour have been openly and clearly outlined to the Medical Staff member.~~

~~(2) This documentation will be forwarded to the subject of the complaint and through the Department Head for inclusion in the Medical Staff member's HR file.~~

~~(3) For Stage Two, Three and Four matters, the documentation will also be forwarded through EMSS for secure inclusion in an EMSS file. EMSS will also prepare a summary report for the CMO's Office.~~

~~(C)~~4.8.3 ~~Managing Unprofessional Behaviour: Stage Zero~~ of Care: Stage One Intervention

~~(1)~~4.8.3.1 The Division Head, Department Head or Chief of Staff/Site-Medical Director ~~will~~shall:

(i) meet with the Medical Staff member involved to describe the alleged incident and why the reported behaviour or care is considered unprofessional or inadequate;

(ii) provide the Medical Staff member with an opportunity to respond;

(iii) assist the Medical Staff member to understand how others have interpreted or received the behaviour;

(iv) provide supportive counselling either personally or through a third party, as appropriate;

(v) in ~~collaboration~~discussion with the Medical Staff member, decide the format and substance of a resolution to the complaint, including a possible response to the reporter if relevant; and

(vi) prepare the ~~Stage Summary~~summary documentation as set out ~~in Article 1.7(E).~~ above.

~~(2) If the Medical Staff member disputes the reported behaviour, disagrees that the behaviour complained of was unprofessional, or the parties are unable to resolve the complaint, then the complaint will be treated as a Stage One complaint.~~

~~(3)~~ This process should be completed within 4 weeks of receiving the complaint~~.~~ if possible.

~~(D)~~4.8.4 Managing Unprofessional Behaviour or Failure to Meet Standards of Care: Stage ~~One~~Two Intervention

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~~(1)~~4.8.4.1 The Division Head, Department Head or Chief of Staff/Site-Medical Director ~~will~~shall follow the process set forth under Stage ~~Zero~~One Intervention ~~at Article 1.7(F).~~.

~~(2) If the Medical Staff member disputes the conduct complained of, or is not prepared to work collaboratively with the Division Head, Department Head or Chief of Staff/Site Medical Director to address the conduct complained of, then the Division Head, Department Head or Chief of Staff/Site-Medical Director will inform the CMO and Chair of HAMAC who will schedule a review by the Discipline Subcommittee of the HAMAC.~~

~~(E) Managing Unprofessional Behaviour: Stage Two Intervention~~

~~(1) The Division Head, Department Head or Chief of Staff/Site-Medical Director will follow the process set forth under Stage Zero Intervention at Article 1.7(F).~~

~~(2)~~4.8.4.2 ~~The Division Head, Department Head or Chief of Staff/Site-Medical Director will~~shall then work with the Medical Staff member to develop a contract between the Medical Staff member and ~~Island Health~~VIHA, which will include the following ~~elements~~:

(i) method of redress (including but not limited to education, practice supervision, coaching, counselling, psychological or other medical testing, leadership training, substance ~~abuse~~use therapy, written project~~,~~ or tutorial sessions~~, etc~~) including consideration of referring the Medical Staff member to an external resource such as the Practitioner Health Program, or retraining or supervision of practice in another program with regular reports to be received by the Department Head and EMSS;

(ii) method of monitoring for change/progress;

(iii) description of behaviour benchmarks;

(iv) time frame within which progress must be demonstrable; and

(v) consequences for lack of progress or non-compliance.

~~(b)~~4.8.4.3 ~~Notify~~The Division Head, Department Head or Chief of Staff/Site-Medical Director shall notify the Medical Staff member in writing that another incident ~~may~~will result in review by the Discipline Subcommittee of the HAMAC in accordance with the Bylaws and that impact on Medical Staff Privileges may be ~~discussed~~determined at that time.

~~(3) If the Medical Staff member disputes the conduct complained of, or is not prepared to work collaboratively with the Division Head, Department Head or Chief of Staff/Site-Medical Director to address the conduct complained of, then the Division Head, Department Head or Chief of Staff/Site-Medical Director will~~

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~~inform the CMO and Chair of HAMAC who will schedule a review by the Discipline Subcommittee of the HAMAC.~~

~~(F)~~4.8.5 Managing Unprofessional Behaviour or Failure to Meet Standards of Care: Stage Three Intervention

~~(1)~~4.8.5.1 The Division Head, Department Head or Chief of Staff/~~-~~Site Medical Director shall immediately inform the CMO and Chair of HAMAC who ~~will~~shall schedule a review of the complaint by the Discipline Subcommittee (DSC) of the HAMAC.

~~(2)~~4.8.5.2 The ~~Discipline Subcommittee will~~DSC shall:

(i) Review the behavioural and/or clinical care history of the Medical Staff member; and

(ii) Recommend ~~to ?~~ other rehabilitation strategies or recommend disciplinary action as appropriate.

~~(3)~~4.8.5.3 Disciplinary action that the DSC and HAMAC may ~~be recommended~~recommend includes but is not limited to:

(i) ~~a~~ modification, ~~refusal,~~ suspension, revocation, or ~~failure~~refusal to renew a Medical Staff member's Privileges to practice within ~~Island Health; and~~VIHA.

~~(ii)~~(i) setting conditions, such as a requirement to complete a course or other remedial training, or a requirement ~~that~~ to undergo an audit, or~~—~~ external reviews of the Medical Staff member's practice.

~~(4)~~4.8.5.4 Action on these recommendations ~~will~~shall follow the process outlined in Article 11.2 of the ~~Medical Staff~~ Bylaws. ~~[NTD: Consider process flow with discipline committee ,HAMAC and board]~~

~~(5) Documentation of Stage Three Interventions will remain in the Medical Staff member's file for a minimum period of ten years, unless there are further incidences of unprofessional behaviour which is substantially similar nature. This documentation will be securely maintained within the office of the Department Head office and by EMSS.~~

~~(G)~~4.8.6 Managing Unprofessional Behaviour: ~~Stage Four/~~Crisis Intervention

4.8.6.1 Where ~~behavior is warranted~~behaviour is too egregious or care deemed too unsafe to ~~require a Stage Four/Crisis Intervention~~warrant staged intervention, the Division Head, Department Head or Chief of Staff/ Site Medical Director shall request the CMO or his/her delegate to consider ~~immediately suspending the Medical Staff member's~~ summary suspension of Privileges as per Article 11.2 of the ~~Medical Staff~~ Bylaws. The CEO is also authorized to suspend per the Bylaws.Where the CMO or CEO are not immediately available, any medical staff leader has the authority to suspend the Practitioner, and shall notify the CMO or CEO verbally and in writing of

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the suspension as soon as circumstances permit.

~~(1)~~4.8.6.2 Crisis intervention is required in the event of the sudden appearance of behaviour or aberrency of clinical practice that is too egregious for a staged response. For all crisis situations, medical leaders must contact the Chief Medical Officer for direction. These issues will be dealt with as expeditiously as possible.

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