**Medical Staff Rules**

**for the**

**Vancouver Island Health Authority (Island Health)**

**DRAFT 11, VERSION 3**

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**Definitions:**

|  |  |
| --- | --- |
| Administrator on-Call | The senior administrator who acts as the primary VIHA contact outside regular working hours and who can be reached 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 current medication, obtained through a systematic process of interviewing the patient or family and review of at least one other reliable source of information. The BPMH documents all current prescription and non-prescription medication, including drug name, dose (amount or volume), route, frequency and duration. |
| Board of Directors | The governing body of the VIHA. |
| Bylaws | The VIHA 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), 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 into the Electronic Health Record (see below) by a care provider or designated medical staff member using either single orders or groups of orders (electronic clinical order sets). |
| Dentist | A member of the medical staff duly licensed by the College of Dental 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 | A member of the Active Medical Staff, appointed by a Department Head to lead the clinical, academic, quality-improvement and governance activities of a Division. |
| Electronic Health Record (EHR) | An IHealth-based summative electronic document replacing the traditional health record of a patient, client, or resident. The EHR is specifically designed to support clinicians by providing access to complete and accurate health data, alerts, reminders, clinical decision support, links to relevant clinical databases and other aids. |
| Electronic Medical Record (EMR) | A summative electronic document replacing the traditional health record of a patient in a private practitioner’s office or clinic setting. An EMR contains patient medical information that can be accessed electronically and linked with other databases, such as an EHR. |
| Enhanced Medical Staff Support (EMSS) | An administrative team that supports medical leaders by assisting them to address professional practice issues in the workplace by enhancing their capacity 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 to the 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 recognized by a university program who has been accepted by VIHA for further training in a clinical discipline. |
| Freedom of Information and Protection of Privacy Act ("FOIPPA") | A provincial act ("FOIPPA") that regulates the information and privacy practices of "public bodies" such as provincial government ministries, local governments, crown corporations, local police forces, hospitals and schools. |
| Health Authority Medical Advisory Committee (HAMAC) | The advisory committee to VIHA on medical, dental, midwifery and nurse practitioner practice *matters*, as described in Article 8 of the Medical Staff Bylaws. |
| Health Record | A digital or hard-copy version of the patient medical chart. |
| IHealth | The platform VIHA uses to access, edit and manage a patient EHR. |
| Interdisciplinary Team | The integrated group of practitioners, nurses and allied health professionals involved in the care of a patient. |
| Local Medical Advisory Committee (LMAC) | 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 who reports directly to an Executive Medical Director and who normally holds Privileges as a member of the medical staff. |
| Medical Lead | A member of the Medical Administration who reports directly to a Medical Director and who normally holds Privileges as a member of the medical staff. |
| 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 practitioner-advocacy arm of the Medical Staff, comprised of all members of the medical staff, whose professional interests are represented by their elected officials as outlined in 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 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 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-Centred Care | Care that places the patient 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 College | The discipline-specific regulatory body for a member of the medical staff. |
| Resident | A physician-in-training who has received a medical degree and who is undertaking additional specialty training in a facility owned or operated by VIHA. |
| Section Head | A member of the Active Medical Staff appointed by a Division or Department Head to lead the clinical, academic, quality-improvement and governance activities of a Section. |
| Trainee | A licensed practitioner who has applied to and been accepted by VIHA for further clinical training. |
| Unprofessional Behaviour | Behaviour that contravenes the code of professional conduct of a practitioner’s regulatory college or professional association, or Island Health policy. |

# Article 1: Good Medical Practice

## Preamble

The Medical Staff are essential to the delivery of effective care to patients and their families across the Vancouver Island Health Authority (VIHA). The Medical Staff maintain their respected status by modeling the ethics, values and professionalism expected by society, regulatory bodies, VIHA, and other healthcare team members.

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 Healthcare Improvement [(IHI)](http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx) as a guiding principle. Its three major elements focus on improving the health of the population, reducing the cost per capita of healthcare and improving both the patient experience of care. VIHA has also embraced as a 4thguiding principle that of improving the provider experience, which is included in the VIHA concept of a ‘quadruple aim’.

VIHA has adopted a set of core values (CARE) that reflect the organization’s commitment to serve the different communities across its diverse 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—to give the kind of care we would want for our loved ones. VIHA has adopted a learning organization philosophy embracing creativity, innovation and excellence in service delivery.

## 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’s representative, as outlined in Section 3(1) of the *Hospital Act Regulation.* The Board 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 VIHA.

The Hospital Act Regulation requires the Board to organize a Medical Staff in conformity with the Medical Staff Bylaws (Bylaws), the Medical Staff Rules (Rules) and VIHA’s policies and procedures.

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 Rules are established by the Board upon the recommendation of the Health Authority Medical Advisory Committee (HAMAC) pursuant to Article 12 of the Bylaws. 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 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 for the quality of medical care they provide in the Facilities and Programs operated by VIHA. The Rules detail the responsibilities of Medical Staff in an organization committed to excellent care. The Rules promote positive interactions with colleagues, medical and administrative leaders, other healthcare professionals and other team members. This ensures appropriate support for team members to work to their full professional scope of practice while meeting individual and organizational goals and objectives.

## Patient Privacy & Confidentiality

Medical Staff have a duty of confidentiality to patients. [FOIPPA](http://www.bclaws.ca/Recon/document/ID/freeside/96165_00) applies to the collection, use, disclosure, and care of patients’, clients’ and residents’ personal information, as well 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 meets specific exceptions as outlined in FOIPPA. Individuals have the right to review and ask for corrections to their personal information.

## Respectful Workplace Policy

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

##### treated with dignity and respect, free from discrimination and harassment; and

##### supported in managing workplace conflict.

### VIHA and its Medical Staff are committed to providing a 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 VIHA [Respectful Workplace Policy](https://intranet.viha.ca/pnp/pnpdocs/respectful-workplace-policy.pdf).

## Transitions of Care & Patient Safety

* + 1. Most Responsible Practitioner (MRP)

##### The MRP is the Medical Staff member who agrees to be the primary care provider for a patient admitted to a VIHA-operated Facility. The MRP is established on the basis of whose scope of practice is best suited to 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 intervention and treatment, or at the time a decision to admit is made in the Emergency Department.

#### 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 is the Practitioner responsible for 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.

#### 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.

#### If the patient’s medical condition warrants consultation with other members of the Medical Staff, the MRP coordinates and facilitates that care.

#### During a patient’s admission, the role of the MRP may be transferred, based upon the changing acuity and nature of the patient’s medical condition.

#### The MRP is responsible to:

###### Accept patients for admission from the Emergency Department (ED) or following acceptance of a transfer-of-care request from another Practitioner;

###### Complete and document a full assessment for admission, including a full history, physical examination and continuing-care orders;

###### Work collaboratively with team members to develop a Best Possible Medication History (BPMH) and order appropriate medications;

###### 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. Responsibility for Residential Care patients is addressed in Article 3;

###### Communicate with the patient and the patient’s primary-care Practitioner regarding medical conditions, tests and planned consultations, including test results. This information may be shared with other parties only with the patient’s consent or as required by law;

###### Work collaboratively with healthcare team members;

###### When necessary, clarify and resolve apparent treatment or management conflicts among care providers;

###### Facilitate and coordinate discharge to the community and communication with the primary-care Practitioner, where present, as well as with community support teams; and

###### Ensure medication reconciliation and prescriptions are available upon discharge until the patient can be followed in the community.

### Most Responsible Practitioner for Admissions from the Emergency Department (ED)

#### When a patient requires admission from the ED, the emergency physician (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 selecting the practitioner or service that customarily manages patients with the most-responsible diagnosis necessitating the admission.

#### A Practitioner with admitting privileges must be available personally or through an on-call service to accept the MRP role. Once a patient has been accepted, the Practitioner assumes primary responsibility for the care and disposition of the patient up to the time that transfer-of-care is accepted by another Practitioner or the patient is discharged back to the community.

#### If, prior to accepting MRP but after personally seeing and assessing the patient, 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 EP regarding the most appropriate Practitioner or service to assume MRP responsibility.

#### Where an admission disagreement persists, the EP shall contact the Head(s) of the Division(s) or Department(s) to which the Practitioners in dispute are assigned. If this is not possible or unsuccessful, the EP should contact the Site Chief of Staff (or designate). After hours, a Senior Medical Director is also available to the VIHA Executive-on-Call, who can provide assistance. At the earliest opportunity during regular working hours the incident shall be reviewed by the appropriate Department Head(s), who will determine next steps to prevent further conflict, up to and including reporting the incident to the HAMAC Chair and CMO if necessary.

### Most Responsible Practitioner for Care in Out-Patient Facilities

#### Only Practitioners with appropriate Privileges may write orders for patients who require medical or mental-health treatment in out-patient Facilities operated by VIHA.

#### A Practitioner wishing to treat a patient in an out-patient Facility must be designated as the MRP and maintain responsibility for all subsequent care ordered and carried out in the Facility, whether or not the Practitioner is physically present at the site.

#### In exceptional circumstances, the CMO or designate may authorize a non-privileged Practitioner to order or provide care in an out-patient Facility, as determined on a case-by-case basis.

### Consultations and Transfer of Care

#### The MRP should make a consultation request directly 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.

#### A consultation is a request for a professional opinion, advice or support in the management of a patient. The 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, using the VIHA EHR wherever it is implemented. The evaluation should provide a clinical opinion, recommendations for management and/or treatment, and the basis for the advice given. The consulting Practitioner shall notify the MRP on completion of the consultation in a timely and mutually acceptable manner.

#### A consultation may result in an opinion only or an expectation of continued management in the area of 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 shall be acknowledged directly in the patient’s clinical record. Direct care includes ongoing evaluation and treatment of the patient’s condition and communication with the patient, family, MRP, other Practitioners involved in the patient’s care and the multidisciplinary team, as appropriate.

#### A transfer-of-care request is a direct Practitioner-to-Practitioner conversation to transfer MRP status or specific care responsibilities to another Practitioner. Practitioners making such a request shall provide a detailed report summarizing the care given to the patient up to the point of transfer, including orders, medications, and the care plan in place at the time of transfer. Transfer-of-care does not occur until the accepting Practitioner provides written or verbal acceptance documented in the patient health record.

#### Reports

###### All consultations and transfer-of-care documents shall follow best-practice guidelines established by the Royal College of Physicians and Surgeons of Canada [(RCPSC)](http://www.royalcollege.ca/rcsite/home-e) or the College of Family Physicians Canada ([CFPC](http://www.cfpc.ca/Home/)). Where IHealth is implemented in a VIHA Facility, these documents must also meet or exceed IHealth documentation standards. These reports are subject to practice audits to ensure compliance with documentation standards.

###### 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.

#### Urgency of Consultation

###### To ensure timely information transfer and intervention, urgent (consultation within 12 hours) or emergent (consultation within two hours) 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.

### Admission of Patients

#### The care of every patient, whether admitted to an in-patient bed or cared for in an out-patient Facility, shall be directed by an appropriately privileged MRP.

#### Patients admitted for in-patient dental surgery by a member of the Dentistry staff shall be admitted under the care of a physician or nurse practitioner on the Active Medical staff who shall act as the MRP. For day-surgery dental procedures, a complete, recently-documented medical history and physical exam performed by a duly-licensed physician or nurse practitioner is an acceptable substitute, provided the documentation accompanies or precedes the patient to day surgery.

#### A complete medical history and physical examination is required for all admitted patients within 12 hours of admission. In VIHA Facilities that have implemented the EHR, the history and physical must be entered into IHealth.

#### Patients admitted through the ED or transferred to a higher level of care must have an initial admission note that includes the presenting problem requiring admission, the results of physical examination and ancillary investigations, as well as an initial care plan provided by the MRP or delegate. In VIHA Facilities that have implemented the EHR, the initial admission note must be entered into IHealth.

#### If a patient is readmitted to an acute-care Facility within two weeks for the same reason as for the previous admission, a new admission note must be completed, including new historical and physical findings since the last admission, a review of allergies and medications, and a mental status assessment.

#### In circumstances requiring an emergency admission, where a Practitioner other than the MRP has provided holding orders, the MRP must provide complete admission orders within 12 hours of the admission.

### Transfer of Patients

#### The MRP shall verbally contact the Practitioner to whom care will be transferred. The transfer of MRP status (other than following “on-call”) from one Practitioner to another shall be duly recorded in the Health Record. This includes transfers to another Facility. The MRP shall inform the receiving site about the patient’s condition and must be informed which Practitioner has agreed to accept MRP responsibility. The transfer shall be followed by an expedited written or dictated summary. In the case of inter-Facility transfers, the summary shall accompany or precede the patient.

#### If a Practitioner wishes to withdraw from patient care after a duty of care has been established, that Practitioner must arrange for another Practitioner with appropriate qualifications to assume that care. A Practitioner who cannot find another qualified Practitioner willing to assume care must meet with the appropriate Division or Department Head to arrange ongoing coverage. Failure to do so constitutes patient abandonment.

#### Where a patient is transferred to another Facility for administrative rather than medical reasons (e.g., lack of available beds at the sending Facility), the MRP, if not assuming the MRP role at the new Facility, shall speak to the receiving Practitioner directly to provide information regarding the plan of care. The Administrator-on-Call at the receiving site will coordinate this conversation to ensure safe and timely access to necessary services.

#### 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 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. Until an alternate Practitioner has accepted responsibility for the patient, the Practitioner providing current care must continue to do so for the patient.

### Repatriation from a Higher-Level-of-Care Facility to a Referring Facility

#### Before a patient is repatriated to a referring Facility, clinical, operational and administrative preparation, including required documentation, must be completed.

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

#### At a minimum, a transfer note, but preferably a discharge summary, completed by the sending Practitioner must accompany the patient upon transfer either as a legible, signed and dated hardcopy delivered with the patient or, where both sites have deployed IHealth, by entry into the EHR.

#### Medication reconciliation and review is a required element of the accompanying documentation delivered with the patient undergoing repatriation.

#### The sending Practitioner must provide sufficient notification, as outlined in VIHA standard-operating procedures, to enable operational planning for the repatriation.

### Discharge of Patients

#### A discharge plan informs care planning from the time a patient is admitted until discharge. The MRP shall document a discharge plan into the patient’s health record within 24 hours of admission. The plan should be updated as part of daily care-planning.

#### The MRP or delegate on-call shall provide a discharge order and complete a discharge summary using a discharge template approved by HAMAC. The summary shall include information about the course in hospital, current and discontinued medications, follow-up plans, patient disposition, advance directives, and recommendations to community Practitioners and healthcare professionals. The discharge summary shall conform to IHealth documentation policy in Facilities where IHealth has been deployed.

#### 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.

#### A discharge summary is required for all in-patient discharges, all deaths and all obstetrics and newborns cases, except for those patients with:

###### An uncomplicated daycare or short-stay surgery;

###### An uncomplicated obstetrical delivery;

###### An uncomplicated neonatal admission; or

###### A short admission where HAMAC and the Board have approved an abbreviated discharge documentation process.

#### For uncomplicated obstetrical admissions, the British Columbia (BC) Antenatal Record Part 1 and 2 shall become an integral part of the patient record. The BC Labour 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 MRP and will form the discharge summary in uncomplicated deliveries.

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

#### 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.

### Reports

#### An operative report is required for all invasive procedures. The report must be dictated immediately upon completion of an operative or other high-risk procedure. If the operative report will not be placed in the health record immediately after dictation, then a progress note must be entered in the health record immediately after the procedure to provide pertinent information to the next care provider(s).

#### The operative report must contain, at a minimum:

###### The patient’s name and health-record number;

###### The name of the primary surgeon and assistant(s);

###### The names of Practitioners who should receive a copy of the report;

###### Date and time of admission;

###### Date of procedure;

###### Pre-operative and post-operative diagnosis;

###### Proposed procedure(s) and indications;

###### Operative procedure(s) performed;

###### Operative complications, if any;

###### The patient’s condition before, during and immediately after the operation;

###### Estimated blood loss; and

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

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

#### 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.

#### 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.

## 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 Practitioners to complete their component of a Health Record remains regardless of the format in which the Health Record is maintained. The [**Clinical Documentation Policy**](https://intranet.viha.ca/pnp/pnpdocs/clinical-documentation-policy.pdf) outlines the accuracy and integrity of clinical documentation required of Practitioners. All Medical Staff shall comply with this policy.

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

### Orders for Medical Treatment

#### Only Practitioners with admitting or consulting Privileges may sign off or authenticate orders for medical treatment in Facilities operated by VIHA.

#### 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 by the person to whom the order is dictated. The ordering Practitioner must sign the order in the paper health record or authenticate it in the EHR within 24 hours of the order having been dictated.

#### A Practitioner may give telephone orders to other professional staff in disciplines such as medical imaging, laboratory medicine, occupational therapy, physical therapy, respiratory therapy, dietary, or pharmacy, who shall document and sign the orders in the EHR, or in the health record where paper-based charts are in use, over the name of the ordering Practitioner.

#### 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.

#### In an emergency a Practitioner may give verbal treatment orders to other members of the care team who shall document and sign the order on behalf of the Practitioner. Following the emergency situation, the ordering Practitioner shall countersign these orders as soon as possible. In Facilities where CPOE is implemented, the Practitioner shall ensure the orders are entered into the EHR and authenticated by the ordering Practitioner.

#### Orders for treatment shall only be given by members of a health profession identified in the Health Professions Act and in accordance with the standards of that member’s College. 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.

#### Medication orders shall follow the standards outlined in the VIHA Medication Orders policy . Orders shall be legible, accurate, contain only approved abbreviations, and adhere to VIHA’s formulary policies.

#### 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.

#### No drug, whether supplied by the VIHA or not, may be administered to a patient without an order from a Practitioner authorized to prescribe that drug. This may include Practitioners outside the scope of these Rules, including nurses and pharmacists.

#### A Practitioner using Clinical Order Sets, whether preprinted or prepopulated in the EHR, is responsible for signing or authenticating them.

### Progress Notes

#### Progress notes for acute-care patients shall be documented by the MRP daily, or more frequently as determined by the evolving condition of the patient.

#### Progress notes shall document:

###### The date and time of assessment or intervention;

###### Any material change in the patient’s condition;

###### Active monitoring, investigation and treatment, including the management of a problem list; and

###### Any revision to the anticipated date of discharge, discharge plan or prognosis.

#### Progress notes for Alternative-Level-of-Care (ALC) patients must be documented in response to a change in the patient’s condition.

### Completion of Health Records

#### 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 Policy approved by HAMAC and the Board.

#### The health record may be filed as incomplete only under the following extenuating circumstances:

###### Medical Leave of Absence greater than three months;

###### Resignation from the VIHA Medical Staff;

###### Retirement; and

###### Death.

#### If the MRP is no longer available to complete the health record(s) due to circumstances outlined in Article 1.6.5.2 above, the appropriate Division Head, Department Head or Chief of Staff shall review the record and provide written authorization to file the Health Record as incomplete.

#### 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 directly.

#### Prior to planned absences, the Practitioner shall complete all outstanding health records. Practitioners who have notified the Health Records Department in writing prior to their absence will not receive an administrative suspension for incomplete records identified during their absence. Outstanding records shall be completed within 14 days of the Practitioner’s return.

#### Locum tenens Practitioners (locum tenens) are responsible to complete the Health Records of patients for whom they have been MRP during the locum-tenens period. The Practitioner the locum tenens replaced is responsible to complete health records left incomplete by the locum tenens.

#### The Health Records Department shall provide the responsible Practitioner with written notification of incomplete health records. The Practitioner shall complete the identified records within 14 days of this notice being issued. Should the records remain incomplete after that time, a seven-day pre-notification of administrative suspension will be issued. Subsequent failure to complete outstanding records shall result in an administrative suspension of all Privileges except that the Practitioner shall continue to provide ongoing care for patients already admitted to hospital and to fulfill medical department on-call obligations until the records are complete.

#### After a Practitioner receives three automatic suspensions in any consecutive 12-month period, HAMAC may impose an automatic full suspension for up to 30 days.

### Release of Health Records

#### All health records maintained in VIHA-operated Facilities, paper-based or electronic, 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 Department, as outlined in VIHA health-records policy.

#### Community-based paper health records may travel with the patient, family or caregiver during the provision of care.

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

#### A Practitioner may access all available VIHA patient health records as long as the Practitioner is MRP or has been asked by the MRP to be clinically involved in that patient’s care.

#### Confidentiality of patient medical information is of utmost importance. Practitioners shall adhere to:

###### Federal or provincial legislation governing privacy and access to health records; and

###### VIHA policies governing privacy and access to health records.

## Medical Staff Membership and Privileges

### Well-defined processes for application and maintenance of Medical Staff membership and Privileges within Facilities operated by VIHA are essential. Terms and criteria for appointment and membership are detailed in Article 3 of the [Bylaws](https://intranet.viha.ca/pnp/pnpdocs/medical-staff-bylaws-vancouver-island-health-authority.pdf). Procedures for application, appointment and review are detailed in Articles 4 of the Bylaws. VIHA supports consistency and transparency in these processes.

### Procedure to Address Application Requests when No Vacancy Is Declared

#### The procedures for application, appointment and review are set out in Article 4 of the Bylaws.

#### Individuals who submit unsolicited letters of intent to apply for membership on the Medical Staff will be notified in writing that no vacancy exists. A copy of each letter will be sent to the appropriate Department or Division Head for information.

#### An unsolicited letter of intent to apply for membership on the Medical Staff does not constitute an application in accordance with Article 4.1.3 of the Bylaws.

### Appointment to the Medical Staff

#### Terms and criteria for Appointment to the Medical Staff, as well as procedures for application and review, are detailed in Articles 3 and 4 of the Bylaws.

#### Appointments to the VIHA Medical Staff are Health-Authority wide.

#### Privileges define the scope and location of 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.

#### Procedural Privileges are a permit to perform specific operations or procedures in Facilities and Programs operated by VIHA. Procedural privileges are:

###### Assessed using specialty-specific British Columbia [Provincial Privileging Dictionaries](http://bcmqi.ca/privileging-dictionaries/); and

###### 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.

#### 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.

#### Each Practitioner will be assigned to a Primary Department. HAMAC shall consider requests for cross-appointment to other Departments 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.

#### An active or consulting staff member may apply for Privileges in another Facility or Program operated by VIHA. Additional privileges may be granted by the Board following review of a recommendation by HAMAC.

#### The process for specialist recruitment to the Medical Staff is defined in VIHA Policy #3.1.2: [Specialist Physician Recruitment](https://intranet.viha.ca/pnp/pnpdocs/specialist-physician-recruitment.pdf). The appointment of a specialist requires completion of a VIHA Impact Analysis and is governed by Article 3.1.5 of the Bylaws.

### Medical Staff Categories

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

###### Provisional staff;

###### Active staff;

###### Associate staff;

###### Consulting staff;

###### Temporary staff;

###### Locum tenens staff;

###### Scientific and Research staff; and

###### Honourary staff.

### Locum Tenens Staff

#### 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.

#### 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.

#### 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.

#### 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.

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

#### 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.

#### 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](https://intranet.viha.ca/pnp/pnpdocs/medical-staff-definition-leave-absence.pdf) to Article 1.7.14 of these rules).

#### Appointment to the Locum Tenens staff conveys no preferential status or privilege in seeking a future appointment to any category of the Medical Staff

### Application & Maintenance of Locum Privileges

#### 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.

#### Minimum lead times for Locum Tenens category privileges are:

###### New Applicants: 6 weeks

###### Current Locum Tenens Staff requesting additional site privileges: 2-4 weeks.

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

#### 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.

#### Performance appraisals will be completed annually or at the conclusion of the locum period, as determined by the Division or Department Head, and placed on the locum’s personnel file.

### Responsibilities of the Medical Staff Member Requesting a Locum Tenens

#### 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 end dates, within the required minimum lead time.

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

#### The Medical Staff member is responsible for the orientation of the locum-tenens practitioner to the facility, including orientation to program policies and procedures 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.

#### 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.

#### 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.

### Responsibilities of Locum Tenens Practitioner

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

#### 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.

#### 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.

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

#### 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.

### Temporary Staff

#### The purpose of an Appointment to the Temporary Medical Staff is to fill a time-limited service need. Further details are outlined in Article 6.5 of the Bylaws.

#### Appointment to the Temporary staff conveys no preferential status or privilege in seeking a future appointment to any category of the Medical Staff.

#### Under normal circumstances, a Temporary staff appointment must follow the policies and procedures used for any other Medical Staff appointment; in special or urgent circumstances, however, where temporary Medical Staff may need to be appointed quickly, the EVP & CMO, on the authority of the CEO, may grant Temporary Privileges for a specified purpose and period of time. Examples include:

###### privileges required for organ retrieval;

###### demonstrating equipment or new procedures;

###### providing care during mass casualties; or

###### 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 at its next scheduled meeting.

### Interim Appointment

#### 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.

#### 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.

#### The 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.

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

#### The purpose of the Interim Appointment shall be indicated clearly in writing to the Practitioner and the applicable Department Head.

#### Interim Appointments permit applicants to practice for the defined term in the Medical Staff category to which they have applied.

#### An Interim Appointment conveys no preferential status or privilege in seeking a future appointment to any category of the Medical Staff.

#### The application of a Practitioner granted an Interim Appointment must be reviewed at the next HAMAC meeting and forwarded to the Board for decision at the Board’s next scheduled meeting.

#### In the event that the Board does not approve the appointment of an applicant with an Interim Appointment, the applicant shall cease all clinical activity in the Facilities and Programs operated by VIHA and immediately transfer the ongoing care of any admitted patients to an appropriate member of Medical Staff.

### Clinical Fellows

#### 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.

#### 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.

### Clinical Trainees

#### 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.

#### 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.

### Students

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

###### 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.

###### They must hold a valid educational license from their professional College in British Columbia.

###### 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.

###### 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.

###### Students shall not sign certificates of death.

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

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

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

###### 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.

###### 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.

### Leave of Absence

#### An absence from Medical Staff practice for a period between six (6) weeks and 12 months is considered a Leave of Absence (LOA). Each LOA requires approval by the Board as outlined in Article 4.7.2 of the Bylaws

#### .

#### 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.

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

### Reappointment to the Medical Staff

#### The process for reappointment is set out in Article 4.4 of the Bylaws.

#### VIHA Policy #3.3.2P provides additional information and guidance on processes related to Reappointment.

### Maintenance of Current Practitioner Information

#### Practitioners shall inform VIHA of any changes that may affect their ability to practice 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.

#### Practitioners shall keep 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).

### In-Depth Practitioner Reviews

#### 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.

#### 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. Theyare intended to be used for periodic reviews of all Practitioners on a three year basis, The process for reviews is set out in Article 4.5 of the Bylaws.

#### 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 to the review meeting with the Department Head or delegate. The Department Head may seek input from sources including a health record review, outcome measures, incident reports or complaints, multi-sourced feedback from team members, and interviews with appropriate senior staff.

#### The practice and performance review may be completed by:

###### A Department Head

###### A Division Head

###### The Chief of Staff of the local Facility, or

###### An external reviewer, approved by the HAMAC on the recommendation of the Department Head, Executive Medical Director or EMD & CMO.

#### The Department Head or delegate 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.

#### The MPCC, as defined in Article 2.5.9.22, shall support the process for performance-reviews and report any concerns regarding consistency, validity and procedural fairness to HAMAC.

### Mid-Term Changes to Privileges

#### 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.

#### 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.

# Organization of the Medical Staff

## Medical and Academic Affairs (MAA)

#### [Medical and Academic Affairs](http://www.viha.ca/physicians/medical_affairs/) is the administrative department that supports the Medical Staff Organization and its leaders by developing and implementing policies and procedures that support:

###### Effective recruitment;

###### Credentialing and privileging;

###### Onboarding and orientation;

###### Quality and performance improvement;

###### Medical Staff governance;

###### Contract management and remuneration and;

###### Continuing professional development

###### Medical staff wellness and resilience

### Chief of Staff

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

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

#### 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.

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

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

###### Monitor and enhance medical governance within the Facility.

###### Act as the liaison for all Department Heads at the Facility

###### Exercise emergency executive function for a Department Head as required.

#### The CoS:

###### Co-develops and co-implements plans to engage and support Facility Practitioners and staff through change;

###### Engages administrative and medical leaders to anticipate, assess, monitor and prioritize Facility needs within the available resources; and

###### 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.

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

## Organization of the Medical Staff

### 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).

### In accordance with Article 7 of the [Bylaws](https://intranet.viha.ca/pnp/pnpdocs/medical-staff-bylaws-vancouver-island-health-authority.pdf), the Board, upon the advice of the HAMAC, shall organize the Medical Staff into Departments, Divisions and Sections.

### All members of the Medical Staff shall belong to at least one Department and maintain privileges in at least one site, as outlined in Article 2.9.15 of these Rules.

### Departments

#### The Medical Staff Departments in VIHA shall be:

###### Pathology and Laboratory Medicine;

###### Imaging Medicine;

###### Medicine;

###### Psychiatry;

###### Maternity Care & Pediatrics;

###### Primary Care;

###### Surgery;

###### Anesthesiology, Pain & Perioperative Medicine; and

###### Emergency & Critical Care Medicine.

#### Departments are Health-Authority wide structures. Activity within Departments is specific to each site.

#### All Departments will not necessarily have members or Division Heads at every site, reflecting local requirements and resource availability.

### Divisions

#### Departments may be further organized into Divisions.

#### At tertiary-care Facilities, Divisions may be organized into Sections.

#### Divisions are clinically-defined specialty groups within a Department.

#### Divisions will not necessarily have members at every site, reflecting local requirements and resource availability.

#### Two Divisions, the Division of Public Health & Preventative Medicine and the Division of Nurse Practitioners, are VIHA-wide stand-alone Divisions, with voting membership on the HAMAC.

### Sections

#### Sections are clinically-defined sub-specialty groups of Practitioners within a Division.

#### All Sections will not necessarily have members at every site, which reflects both local need and resource availability.

### Meetings

#### Each Department shall meet two times per year, and at the call of the Department Head to conduct its administrative affairs as outlined in Article 7.2 of the Bylaws.

#### Department Heads shall meet with their Division Heads at a minimum of four (4) times per year.

#### 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.

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

#### Meetings may be in person, by video or teleconference.

#### Active Members of Medical Staff are required to attend at least 70% of primary departmental/divisional meetings.

#### Departmental Leadership meetings shall follow the meeting governance and operations processes as outlined in [Article 2.5 (A)](#_Governance_and_Operations) of these Rules.

## Medical Staff Departmental Leadership

### In VIHA, the Bylaws define and the Rules amplify clarify the roles and responsibilities of Practitioners and their leaders as Department, Division and Section Heads. These leaders provide 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 interest.

### Physician-leadership oversight roles are articulated in this Article of the Rules and address:

###### Standards of Care & documentation;

###### Recruitment, resource planning;

###### Privileging;

###### Performance monitoring & improvement;

###### Education and research;

###### Professional Competence and Behaviour;

###### Individual Provider Quality; and

###### Medical staff wellness and resilience

### Department Heads

#### The responsibilities of the Department Head are outlined in Article 7.2 of the Bylaws.

#### The Department Head has VIHA-wide responsibilities.

#### The Department Head shall be an Active-Staff member of the applicable Department who provides governance and leadership to Department members in accordance with the Bylaws and Rules.

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

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

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

#### 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.

#### The Department Head reports to the CMO.

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

#### 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.

#### The Department Head shall identify an Assistant Head to assume the responsibilities of the role in the Department Head’s absence.

#### In addition to those duties outlined in Article 7.2 of the Bylaws, the Department Head shall:

###### Lead the development of procedures to create and routinely monitor medical practice standards, including the use of standards for practice assessment;

###### Monitor and anticipate Department workforce needs, and collaborate with Medical and Academic Affairs to help address those needs those needs through effective recruitment;

###### Lead the implementation of procedures to support Department members to participate in medical education and research;

###### Ensure the Department workforce plan provides sufficient staff to meet clinical requirements while accommodating medical-education and research activities;

###### Monitor and facilitate improved quality of practice for individual Department members;

###### Collaborate in the development of robust Practitioner recruitment.

###### Attend to Credentialing and Privileging requirements;

###### Implement a process for periodic in-depth Practitioner review;

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

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

#### The CMO shall be responsible for conducting a regular performance review of each Department Head.

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

#### 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.

#### If a Department Head resigns or is removed, the Assistant Department Head shall assume the responsibilities of the Department Head until a successor has been appointed. In the absence of an Assistant Department Head, the CMO may assume or delegate this role after consultation with the HAMAC Chair.

#### 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.

### Division Head

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

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

#### Division Heads have cross-Facility responsibilities.

#### The Division Head shall be an Active Staff member of the Division who provides governance and leadership to Department members in accordance with the Bylaws and Rules

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

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

#### The Division Head collaborates with the Department Head to ensure the provision of high-quality clinical services by Practitioners within the Division.

#### The Division Head assists the Department Head by completing QPID activities for the Division.

#### The Division Head attends and participates on committees in consultation with the Department Head.

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

### Section Head

#### The responsibilities of the Section Head are outlined in Article 7.2 of the Bylaws.

#### The Section Head generally fulfils the same role for the Section as the Division Head does for the Division.

#### Section Heads may have cross-Facility responsibilities.

#### The Section Head is an Active Staff member of the Section who provides governance and leadership to Section members in accordance with the Bylaws and Rules.

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

#### The Section Head shall be appointed by the Division Head after consultation with Section members.

#### The Section Head collaborates with the Division Head to ensure the provision of high quality clinical services by Practitioners within the Section.

#### The accountabilities of the Section Head are similar to those of the Division Head, but at the Section level.

#### The Section Head assists the Division Head by completing QPID activities for the Division.

#### The Section Head attends and participates on committees in consultation with the Division Head.

#### The term of appointment for a Section Head shall five (5) years, renewable once.

### On-call coverage for admitted patients

#### Practitioners with MRP Privileges to practice in Facilities operated by VIHA have a professional obligation to be continuously available to meet the medical needs of their admitted patients.

#### Groups of Practitioners with a similar scope of practice may join together in call-groups to share the requirements of after-hours care. These Practitioners shall create an on-call rota to ensure 24-hour coverage for the group’s in-patients in a manner acceptable to the group and the CMO.

#### On-call Responsibilities for Emergency-Department (ED) patients or admitted patients who require urgent consultation from non-MRP Practitioners

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

###### ED patients who require urgent consultation or in-patient admission; and

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

#### 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.

#### 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.

#### The Department Head or delegate shall develop a list of Practitioners belonging to each call group within the Department, and maintain an on-call rota that shall be provided in advance to the VIHA switchboard.

#### Wherever possible, call-group members should share equivalent qualifications to ensure consistency of patient care.

#### Where community size or Practitioner numbers necessitates a call group whose Practitioners have different skillsets, the call-group members must establish a group on-call strategy to ensure all medical needs of the patient are met.

#### Where call-group members practice in different communities, the members may 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 after consultation with the applicable geographical Division Head(s).

#### 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.

#### 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.

### On-call scheduling

#### The establishment of an on-call schedule is mandatory for each call group and must:

###### Provide a Practitioner available to assess and treat the patient(s) at all times;

###### Be maintained in up-to-date fashion at all times;

###### Identify the Practitioner by name, including up-to-date expedited contact information;

###### Identify the Practitioner responsible for maintaining the on-call list, including contact information;

###### Be made available in a manner, time and format acceptable to VIHA in order to distribute it to necessary recipients; and

###### Be submitted by the Department Head or delegate at least 28 days prior to the date on-call is to be provided. Changes to the call schedule must be clearly disseminated in advance to all necessary recipients.

#### The frequency of call is determined by both the needs of the patient and the size of the on-call group.

#### On-call Practitioners shall maintain availability dictated by the patient’s condition and clinical requirements.

#### Departments and Divisions that deal with life, limb, and organ-threatening emergencies shall establish a process to obtain assistance when the first on-call member cannot respond within an appropriate timeframe.

### On-call exemptions

#### A Practitioner may be exempted from providing on-call coverage only when approved by the Board, acting on the advice of the HAMAC and the applicable Department Head.

#### 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 or delegate shall exercise all means available to find a replacement.

#### The Department Head, in consultation with 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 fulfil that member’s on-call obligations.

#### Criteria for partial or full exemptions may include, but are not limited to:

###### Age of the member;

###### Health concerns;

###### Extraordinary personal circumstances; or

###### Other offsetting contributions by the member to the Department or Division.

#### The Department Head shall provide the HAMAC with reasons for a proposed exemption, any changes to an already-existing exemption and the potential consequences of an exemption, which will assist the HAMAC to provide an appropriate recommendation to the Board.

## Medical Staff Association

#### The Health Authority Medical Staff Association (HAMSA) is a VIHA-wide entity operating in accordance with Article 11 of the Bylaws.

### Purpose

#### The HAMSA shall consist of all members of the Medical Staff, and shall:

###### represent the views of its members both individually and collectively; and

###### be responsible for effective communication with the Medical Staff, Administration and the Board.

### Composition

#### The HAMSA will be represented by the elected members of Site Medical Staff Associations.

### Local Medical Staff Association (LMSA) Meetings

#### Meetings of the LMSAs will be held at least four times per year. One meeting will be an annual general meeting where officers of the LMSA shall be elected for the coming year.

#### The CEO and the CMO or their delegates shall be invited to attend at least one of the meetings per year.

#### A Special meeting of the LMSA may be called at the request of at least 10% of the membership of the LMSA who are eligible to vote (current privileges held).

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

#### Where applicable, notice of a general meeting must include any special resolution to be submitted for consideration.

### Duties of the Local Medical Staff Association

#### The LMSA shall:

###### Advise the Medical Staff through the LMSA Executive Committee of the concerns and opinions of its members;

###### Set the rate and arrange for the collection of annual fees from all members;

###### Administer LMSA funds as determined by the membership;

###### Create and administer programs of interest to the members of the Medical Staff locally, regionally or Island-wide;

###### Meet at the call of the President to nominate a candidate to fill any position vacated during the term of office;

###### Ensure a fair and equitable system of voting for the LMSA Executive;

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

###### 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.

###### 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.

### Attendance

#### Medical Staff members are encouraged and expected to attend 50% or more of their LMSA meetings in a calendar year to stay informed and to ensure that their voice is considered in conducting the business of the LMSA.

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

### Officers

#### The officers of LMSA Executive shall consist of:

###### President/Chair

###### Vice-President

###### Secretary/Treasurer

#### Officers shall serve a term of one year in a given position and may be re-elected for a maximum of three consecutive years in office.

#### The duties of elected officers are outlined in Article 11.2 of the Bylaws.

#### 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.

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

### HAMSA Executive Committee (HEC)

#### Purpose

#### This Committee is responsible to the Medical Staff of Island Health.

#### The HEC:

###### Represents the collective voice of the Medical Staff members;

###### Supports and advises LMSAs in their ongoing work; and

###### Works with the Health Authority to establish Island-wide medical-staff engagement strategies.

#### Composition

#### The HAMSA Executive Committee is composed of all LMSA Presidents or their delegates.

#### Officers of HAMSA Executive Committee include:

###### Chair

###### Vice-Chair

###### Secretary

#### Officers shall be elected for a one-year term in and may be re-elected for a maximum of three consecutive years in that office. The Chair of the HAMSA Executive Committee sits on HAMAC as a voting member.

#### The duties of elected officers are outlined in Article 11.2 of the Bylaws.

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

#### Meetings shall occur at least four times annually and at the call of the Chair.

#### The VIHA CEO, CMO and HAMAC Chair or their delegates may be invited to attend or may request to attend these meetings.

#### Duties

#### The HAMSA:

###### Advises the HAMAC and VIHA of the concerns and opinions of its members and advocates on their behalf;

###### Provides a forum for LMSAs to discuss and develop initiatives and ideas of mutual interest;

###### Encourages members of the Medical Staff to run for office on the LMSA Executive Committees; and

###### Ensures that each LMSA prepares a list of candidates for its Executive positions and conducts a fair and timely election process.

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

## Medical Staff Committees

General Principles of Governance and Operation:

### A simple majority of voting members (50% +1) shall constitute a quorum for the HAMAC and all its subcommittees. A meeting may take place without quorum but no business can be carried out or motions made.

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

### Meetings will operate by consensus. Where consensus is not possible, motions will be decided by a simple majority vote of members present in person or by proxy. In case of a tie, the Chair shall cast the deciding vote.

### Where a procedural query or process dispute arises at a Medical-Staff committee meeting, the most current version of Roberts Rules of Order shall be followed.

### All meetings will be minuted and in accordance with the Medical Staff Committee Governance Standards.

### Each HAMAC sub-committee chair shall provide the names of all committee members to the HAMAC secretariat annually and when changes occur.

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

### All Medical Staff Committees are subcommittees of the HAMAC and report regularly to the HAMAC on proceedings at meetings.

### Health Authority Medical Advisory Committee

#### Purpose and Responsibilities

#### The HAMAC is the senior advisory committee of the Medical Staff as defined in Article 8 of the [Bylaws](https://intranet.viha.ca/pnp/pnpdocs/medical-staff-bylaws-vancouver-island-health-authority.pdf).

#### The HAMAC makes recommendations to the Board with respect to:

###### Appointment and review of members of the VIHA Medical Staff, including the delineation of clinical and procedural Privileges;

###### The quality, effectiveness, and availability of medical care provided within VIHA Facilities and Programs;

###### The establishment and maintenance of professional standards in Facilities and Programs operated by VIHA in compliance with all relevant legislation, the Bylaws, Rules and policies;

###### The resources required by the Medical Staff to meet the needs of the population served by VIHA including, but not limited to, the availability and adequacy of existing resources to provide appropriate patient care;

###### Continuing Professional Development (CPD) of the Medical Staff;

###### The professional and ethical conduct of members of the Medical Staff; and

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

#### The HAMAC receives information from its subcommittees, medical Departments and clinical programs, and provides advice to the Board on based on that information.

#### Appointments to HAMAC:

###### The Chair and Vice-Chair of the HAMAC are appointed by the Board on the recommendation of the HAMAC and the CMO.

###### 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.

#### Voting Members:

###### Chair of the HAMAC

###### Vice-Chair of the HAMAC

###### Vice President Medicine, Quality and Academic Affairs

###### Each VIHA Department Head or delegate

###### One LMAC Chair from each of the four geographies

###### One MSA representative from each of the four geographies, one of whom shall be the HAMSA Executive Committee Chair

###### Chief Medical Health Officer

###### Chief Medical Information Officer

#### Non-voting Members:

###### President and CEO

###### All Executive Medical Directors of Island Health

###### HAMAC standing subcommittee Chairs

###### General Legal Counsel & Chief Risk Officer

###### Executive Vice-President, Quality, Safety & Experience

###### Other members of the senior administrative or Medical Staff of VIHA as appropriate and as agreed between the HAMAC Chair and CMO.

#### 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.

#### 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.

#### The Executive Committee shall plan, develop, prioritize and finalize the agenda items for each regular meeting, as well deal with business arising between meetings at the request of the Chair or CMO.

#### The executive committee shall be comprised of:

###### Chair of the HAMAC

###### Vice-Chair of the HAMAC

###### Chief Medical Officer

###### One MSA representative who is a voting member on the HAMAC

###### Two Department Heads

#### Regular Meetings

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

###### The agenda and related material will be distributed to the membership not less than one week before any regular meeting.

###### 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.

###### There is no maximum term for voting, non-voting and executive members of the HAMAC.

#### Executive Committee

#### Special Meetings

###### The HAMAC may meet to address special issues or urgent matters. The special Meetings are held at the call of the Chair or by request of a majority of members of the HAMAC Executive.

###### A minimum of four days’ notice is required for special meetings unless otherwise noted within these Rules.

###### All members may attend special meetings of the HAMAC but a quorum of voting members of the HAMAC is required for the meeting to proceed. Others may attend by invitation of the Chair or the HAMAC Executive.

#### Organizational Meeting

###### Annually, the HAMAC shall hold a face-to-face meeting open to the HAMAC members, all Chairs of HAMAC subcommittees and others at the discretion of the HAMAC Chair or the Executive.

###### In compliance with the Bylaws, a video-conference meeting will be construed as a face-to-face meeting.

###### Quorum for the organizational meeting will be a simple majority of the regular HAMAC voting membership.

###### The meeting will be for the purpose of receiving reports and confirming membership of the HAMAC and its’ subcommittees. Standing subcommittee reports shall include, at a minimum, work completed over the previous year, and goals for the coming year.

#### Role and Responsibilities of the HAMAC Chair

#### The Chair:

###### Acts as the principle spokesperson for the HAMAC in liaising with the CEO, the CMO and the Board of Directors;

###### Presides at all meetings of the HAMAC;

###### Manages the affairs of the HAMAC between meetings, ensuring that committee responsibilities are discharged in a timely manner;

###### Oversees the secretariat in coordinating and ensuring timely reporting by the subcommittees to HAMAC;

###### Serves as an ex-officio member of all HAMAC subcommittees;

###### Oversees the annual confirmation of the HAMAC membership and appoints subcommittee Chairs;

###### Communicates broadly to the Medical Staff on business decisions, motions and advice provided by the HAMAC;

###### Reports to and attends meetings of the Board of Directors; and

###### Performs other duties as required by the CEO or the Board.

#### Local Medical Advisory Committees (LMACs)

###### 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.

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

#### LMAC Membership

###### The Chair who is the Chief of Staff and Site Medical Director;

###### The President of the site MSA;

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

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

#### Frequency of LMAC Meetings

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

###### The following VIHA Facilities shall establish and maintain LMACs:

###### Cowichan District Hospital

###### Nanaimo Regional General Hospital

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

###### Saanich Peninsula Hospital

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

###### West Coast General Hospital

#### Standing Subcommittees

#### The mandate for each standing subcommittee of the HAMAC is outlined in these Rules. The Board, on the advice of the HAMAC, may establish other committees as well as additional Local Medical Advisory Committees as outlined in Article 10.1 of the Bylaws.

#### Chair and Vice-Chair Appointments to Standing Subcommittees

###### The Chair of the standing subcommittee is appointed by the HAMAC from eligible members of the Medical Staff.

###### 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.

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

###### 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.

#### Role and Responsibilities of Chair of Standing Subcommittees

#### The Chair shall:

###### Act as the principle spokesperson for the standing subcommittee;

###### Preside at all meetings of the standing subcommittee;

###### Manage the affairs of the standing subcommittee between meetings, ensuring the committee responsibilities are discharged in a timely manner; and

###### Ensure the appropriate and timely reporting of minuted business and approved motions of the standing subcommittee to the HAMAC.

#### The Vice Chair assumes the role of Chair in the Chair’s absence.

#### Medical Planning and Credentials Committee (MPCC)

#### Purpose and Responsibilities

###### The role of the MPCC is outlined in Article 4.3 of the Bylaws.

###### The MPCC is responsible for reporting and making recommendations to the HAMAC on:

###### Medical Staff recruitment;

###### Credentialing, privileging, appointment and reappointment;

###### Medical Staff performance review and;

###### Medical Staff recognition.

###### In addition, the MPCC is responsible for:

###### Facilitating resolution of recruitment and privileging issues that cannot be resolved at the Department or Division level.

###### Providing advice on projects and initiatives undertaken by Medical and Academic Affairs related to the Medical Staff.

#### Voting Members

#### Voting members shall be as follows:

###### Chair

###### An operational Executive Medical Director

###### Medical Director, Credentialing, Privileging and Medical Staff Recruitment & Retention

###### Each Department Head or delegate

#### Non-Voting Members

###### An operational Executive Director

###### Director Medical Staff Support

###### Manager Credentialing & Privileging and Medical Staff Recruitment & Retention

###### Two Members-at-Large

#### Frequency of Meetings

###### 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.

#### Legislative Committee (LC)

#### Purpose and Responsibilities

###### The Legislative Committee (LC) makes recommendations to the HAMAC on the development, implementation, monitoring and revision of the VIHA Medical Staff Bylaws, Rules and Policies.

###### 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.

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

#### Voting Members

###### Chair of the Legislative Committee

###### A minimum of 5 voting members of the HAMAC

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

###### Other members of the Medical and/or hospital staff as the Committee deems appropriate.

#### Non-Voting Members

###### Consultants and advisors as deemed appropriate by the HAMAC

#### Frequency of Meetings

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

#### Medical Education Committee (MEC)

#### Purpose and Responsibilities

###### The MEC supports the HAMAC by addressing policy and procedures related to clinical-trainee education and medical staff continuing professional development as outlined in Article 9.3.6 of the Bylaws.

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

###### Educational opportunities for Medical Staff, Clinical Fellows, Residents, and Students working in VIHA;

###### Logistical matters relating to Clinical Fellows, Clinical Trainees, Residents and Students, such as the provision of on-call facilities, health protection services, and code of conduct;

###### Assisting Divisions, Departments and programs in the planning and coordination of educational activities;

###### Advising the HAMAC of rounds, clinical conferences, lectures and symposia being given by each Department;

###### Assisting Divisions, Departments and programs in setting policies for continuing professional development; and

###### Providing representation on the VIHA Library Committee.

#### Voting Members

###### MEC Chair;

###### A representative from each Department responsible for learners;

###### A representative from the Division of Public Health and Preventative Medicine; and

###### A medical-staff representative of the First Nations Health Authority.

#### Non-Voting Members

###### Three learner representatives;

###### A representative from rural and remote sites;

###### The Regional Associate Dean for the Island Medical Program; and

###### Consultants and advisors as the Committee deems appropriate.

#### Frequency of Meetings

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

#### Health Authority Medical Quality Committee (HAMQC)

###### Reporting to the HAMAC, the HAMQC aligns with the VIHA Quality Improvement structure and committees to provide advice and guidance on those aspects of quality improvement and patient safety that fall within the purview of the VIHA Medical Staff.

###### The HAMQC is responsible for the making recommendations to the HAMAC on:

###### Medical staff quality assurance data and measures;

###### Medical quality improvement initiatives;

###### Development and implementation of VIHA QA/QI programs; and

###### Medical Staff-related issues identified by HAMAC that impact the quality of patient care.

#### Voting Members:

###### The Chair of the HAMQC;

###### Three (3) Department Heads or delegate;

###### Four (4) Chiefs of Staff/Site Medical Director or delegate (one from each geography);

###### Medical Director, Residential Care, or delegate;

###### A Medical Staff Association president; and

###### A medical staff representative from the First Nations Health Authority.

#### Non-Voting Members

###### Vice President Medicine, Quality and Academic Affairs;

###### A representative from the Combined Quality Oversight Council (CQOC);

###### A representative from the Quality Operations Council (QOC);

###### The Chief Medical Information Officer or delegate;

###### An Island Health medical staff learner; and

###### An approved patient representative.

#### Frequency of meetings

###### 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.

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

###### Medical-Staff workforce planning;

###### Credentialing and privileging;

###### Individual provider practice quality and performance enhancement;

###### Professional development;

###### Practice standards and documentation;

###### Medical education and research; and

###### Meeting standards of professional behaviour.

#### Ad Hoc Committees

#### Department Head Search Committee (DHSC)

##### The DHSC works with the Chief Medical Officer and Medical Affairs staff to:

###### Develop a position description for the Department Head including a list of required qualifications;

###### Advertise the position in accordance with established VIHA protocols;

###### Coordinate the search and review process;

###### Review applications and documentation from each candidate;

###### Develop a short list of candidates to be interviewed;

###### Organize and conduct an interview process for each short-listed candidate; and

###### Report its recommendations to the HAMAC.

##### 

#### Disciplinary Review Committee (DRC)

#### Purpose and Responsibilities

###### A DRC may be constituted to act as the investigative arm of HAMAC for issues requiring potential disciplinary action as described in Article 12.2 of the Bylaws. These include but are not limited to issues relating to unprofessional behaviour or clinical competence. The DRC does not address summary restriction or suspension as outlined in Article 12.2.1 of the Bylaws, which requires that the entire HAMAC review these matters.

###### In the interest of procedural fairness and due process the following principles will govern the work of the DRC:

###### 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.

###### 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.

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

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

###### 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.

###### The remedial actions that the DRC may consider and recommend include:

###### Reprimand;

###### Restriction, modification, suspension or revocation of privileges; and

###### Non-renewal of privileges.

#### Composition of the DRC

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

###### One member of the HAMAC executive committee who shall serve as chair; and

###### Two other neutral members of the HAMAC or its subcommittees.

#### Meetings of the DRC

###### The committee shall meet at the call of the Chair.

###### Meetings shall be conducted in-camera.

###### All committee members must be present for all meetings.

#### Process

###### 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.

###### 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.

###### 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.

###### 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.

###### 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.

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

###### 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.

## Teaching, Education and Research

Medical Students and Residents are not members of the Medical Staff as defined in the [Bylaws](https://intranet.viha.ca/pnp/pnpdocs/medical-staff-bylaws-vancouver-island-health-authority.pdf).

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](https://www.cpsbc.ca/for-physicians/registration-licensing/applying)) and the College of Midwives of BC ([CMBC](http://cmbc.bc.ca/)).

### Undergraduate Learners

#### Undergraduate learners include medical students and midwifery students.

#### In preparation for training at VIHA students are required to complete specific onboarding requirements as mandated by both UBC and Island Health.

### Medical Students

#### Must have an educational license from the College of Physicians and Surgeons of BC ([CPSBC](https://www.cpsbc.ca/)) in order to train in VIHA Facilities and Programs.

#### May participate in the care of patients under the direct supervision of a Medical-Staff member, or under the supervision of a Fellow or Resident who is under direct supervision of the Medical-Staff member.

#### May perform Procedures under supervision of a Practitioner. They shall not be permitted to attempt Procedures they are inadequately trained to perform or those with any significant potential risk.

#### Must ensure that orders are discussed in advance with and countersigned by the supervising Practitioner, Fellow or resident .

#### 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 resident.

#### May not sign birth and death certificates, mental health certificates or other medico-legal documents.

#### May not sign prescriptions.

#### May not dictate final versions of discharge summaries or consultation letters.

#### Are expected to be on call, but must be directly supervised at all times.

### Midwifery students ([UBC: Midwifery Policies and Procedures](http://midwifery.ubc.ca/student-portal/midwifery-policies/))

#### May participate in the care of patients under the direct supervision of a Midwife member of the Medical Staff.

#### Will complete clinical placements during years two, three and four under the supervision of a Midwife.

#### Will attend antenatal or postnatal encounters. These include clinic, home and hospital in addition to intra-partum and perioperative care.

#### May be responsible for chart entries during clinic or during a labour, birth or postpartum encounter. The student is responsible to ensure the appropriate registered Midwife signs off their notes.

#### Are expected to be on call.

#### May attend Department meetings, practice meetings, educational forums, peer-review sessions, phone consultations with clients and consultants, and prenatal classes.

### Postgraduate Learners ([CPSBC: Postgraduate](https://www.cpsbc.ca/for-physicians/registration-licensing/applying/postgraduate) )

#### 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 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 Health.

### Residents ([UBC Resident Policies and Procedures](#_top))

#### May participate in care of patients under the direct supervision of a member of the Medical Staff, or under the supervision of a more senior Resident who is under direct supervision of the Medical Staff member.

#### May carry out such duties as assigned by the supervising Medical Staff member.

#### Must advise patients of their trainee status.

#### Shall notify their supervisor of their patient assessments and actions taken to provide care. Notification requires direct contact and should be documented in the patient record.

#### May not sign birth or death certificates and may not request autopsies.

#### May not admit patients to a Facility except under the direction of a member of the Medical Staff.

#### Are expected to participate in dictation requirements. All dictated notes must contain the supervising or MRP Practitioner’s name.

#### May be allowed to prescribe any medications, including narcotics under supervision. The name of the supervising Practitioner is to be printed on the prescription.

#### Are expected to be on call.

#### Are expected to attend Departmental clinical conferences and rounds regularly.

### Fellows

#### A Fellow is a post-graduate MD pursuing further clinical or research training in a specialty or sub-specialty. Fellows have successfully met all the requirements for specialist licensure in their home country.

#### A Fellow may participate in VIHA facilities under the following circumstances:

###### They are approved by the appropriate Department or Division Head; and

###### They are recommended by the HAMAC and approved by the Board of Directors.

#### Once approved, Fellows:

###### may attend patients under the supervision of a member of the Medical Staff of the Department responsible for their supervision;

###### may carry out such duties as are assigned to them by the Department Head or delegate to whom they have been assigned;

###### may not admit patients under their name; and

###### may not vote at Medical Staff or Department meetings.

### Medical Staff Preceptors and Supervisors:

#### 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.

#### 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](http://www.med.ubc.ca/clinical-faculty/).

#### All Medical-Staff members are expected to participate in teaching as a condition of their appointment.

#### Medical-Staff members are not responsible for onboarding or verifying that learners have met all the onboarding requirements as mandated by UBC and VIHA.

#### 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.

#### 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.

#### 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.

#### Supervisors and preceptors shall assess, review and document trainee competence in accordance with UBC policies.

### Research

#### 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:

###### Individuals conducting research at Island Health must comply with [Policy 25.3 Research Integrity](https://intranet.viha.ca/pnp/pnpdocs/research-integrity.pdf), as well as any other applicable VIHA research policies and procedures.

###### Research conducted at VIHA requires VIHA [Research Ethics approval](http://www.viha.ca/rnd/research_ethics/ethicsapp.htm).

###### Approval must be obtained from all VIHA Department(s) involved in the support or conduct of the research project.

###### 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](https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/applications-submissions/guidance-documents/international-conference-harmonisation.html) (ICH).

# 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.

## Most Responsible Practitioner (MRP)

#### 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.

#### 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.

#### 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.

#### During a patient’s Facility stay, the role of the MRP may be transferred, as outlined below.

##### The MRP:

###### Admits or accepts patients from acute care sites, other Facilities, the community or from another Practitioner;

###### Reviews documentation and augments it as required to ensure that a full medical assessment is completed, including admission and continuing-care orders;

###### 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;

###### Provides periodic care, completes progress notes and oversees the patient’s care in the Facility, either directly or through an on-call group;

###### 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;

###### Works collaboratively with healthcare team members;

###### When necessary, resolves apparent treatment or management conflicts among shared-care providers;

###### 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;

###### Proactively visits each resident with an interval between visits of no more than 90 days;

###### Attends annual multi-disciplinary care conference reviews whenever possible;

###### 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;

###### 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;

###### 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;

###### 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

###### Should a discharge occur, ensure medication reconciliation and prescriptions are available upon discharge until the patient can be followed in the community.

### Most Responsible Practitioner for Residential Care Facilities

#### Only Practitioners with appropriate Privileges may write orders and manage residents who require treatment in licensed residential care facilities operated by Island Health.

#### 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.

#### 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.

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

###### 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;

###### 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;

###### Medical orders to comply with infection-control requirements or recommendations of the Medical Health Officer;

###### Routine medical orders where the MRP has failed to respond to requests for care; and

###### Urgent medical care where the MRP is not available or has failed to respond to requests for care.

###### 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).

### Consultations, Shared Care and Transfer of Care

#### 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.

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

#### 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.

#### 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.

#### 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.

#### 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.

#### 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.

### Reports

#### 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)](http://www.royalcollege.ca/rcsite/home-e) and the College of Family Physicians of Canada ([CFPC](http://www.cfpc.ca/Home/)), 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.

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

### Discharge of Residents

#### 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.

#### A discharge summary is required for:

###### All resident discharges regardless of length of stay; and

###### All deaths.

#### 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.

# Regulated Provision of Care

## 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.

### Membership and Appointment

#### 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.

### Responsibility for Patient Care

#### 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.

#### 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.

#### 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.

## Delegation of a Medical Act

### 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.

### 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 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.

### 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.

## Scheduled Treatments and Procedures

This Article refers to all scheduled medical, surgical and interventional treatments or procedures (hereinafter called “Procedure(s)”) that are scheduled through VIHA booking services.

### Booking Requirements

#### 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).

#### Booking requests shall be submitted in accordance with approved VIHA booking request forms, processes and timelines.

#### Required documentation, in accordance with established VIHA standards, shall be submitted at the time of the booking request.

#### 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.

### Consent Requirements

#### 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.

#### For any individual not involved in the care of the patient, patient consent is always required before observation of any procedure(s) is allowed.

### Requirements for Surgical Procedures

#### A surgeon shall be the Most Responsible Practitioner for peri-operative management of the patient and for the performance of any surgical procedure.

#### 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.

#### Surgery shall only be performed with the assistance of a second Medical-Staff member where VIHA policy so requires.

#### 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.

#### 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.

#### An anesthetic record must be completed before the patient leaves the operating room or post-anesthetic recovery area.

#### 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.

#### Before leaving the operating room, the surgeon shall ensure that the required pathology requisitions have been completed by the OR staff.

#### The surgical record of operation must be dictated or written within 24 hours of the procedure, but preferably immediately post-procedure.

#### 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.

### Requirements for Non-Surgical Treatments and Procedures

#### 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.

## Pronouncement of Death, Autopsy and Pathology

### 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.

### 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.

### In appropriate cases, the Most Responsible Practitioner shall make all reasonable efforts to obtain permission for the performance of an autopsy.

### All tissue or material of diagnostic value shall be sent to the Department of Pathology.

### 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.

### Where the manner of death meets reporting requirements outlined in the *Coroner’s Act,* the death must be reported to the Coroner.

## Reporting & Managing Unprofessional Behaviour

### Purpose

#### 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;

#### To provide transparent processes to manage unprofessional behaviour by members of the Medical Staff, including those in leadership positions.

### Principles

#### Breach of standard for professional or respectful behaviour will be addressed in a consistent, equitable and timely manner.

#### All reports of unprofessional behaviour, received verbally or in writing, will be considered carefully and addressed.

#### 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.

#### 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](#_top) . 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.

#### Reports of unprofessional behaviour will be investigated as soon as possible, usually within two to four weeks.

#### Retaliation of any kind against a reporter of unprofessional behaviour is expressly forbidden and will result in disciplinary action against the perpetrator.

#### 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.

### Managing Unprofessional Behaviour

#### 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 application of consequence. Detailed processes to support the fair and timely management of unprofessional behaviour are identified in Article 4.8 of these Rules.

### Managing 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 technical skill.

#### 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.

### Whistle Blowing Policy

#### 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.

#### Reports under this policy must be made in good faith and based on reasonable grounds.

## 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.

### Interventions have the goal of remediation and will generally follow a staged approach, outlined below:

#### 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.

#### 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.

#### 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.

#### 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 that adversely affects, or may adversely affect, the care of patients, or the safety and security of patients or staff. Stage 3 interventions occur if the situation does not require immediate 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.

#### Crisis Intervention: The sudden appearance of behaviour that is too egregious for a staged response, or where a serious problem or potential problem adversely affects or may adversely affect patient care or the safety and security of patients or staff and immediate action is required. These situations will be addressed in accordance with Article 11 of the Bylaws.

### Uniform Approach for Managing Unprofessional Behaviour

#### 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.

#### 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.

#### Any retributive behaviour by a Medical Staff member against a complainant shall result in immediate escalation of the disciplinary process.

### Managing Unprofessional Behaviour or Failure to Meet Standards of Care: Stage One Intervention

#### The Division Head, Department Head or Chief of Staff/Site-Medical Director shall:

###### meet with the Medical Staff member involved to describe the alleged incident and why the reported behaviour or care is considered unprofessional or inadequate;

###### provide the Medical Staff member with an opportunity to respond;

###### assist the Medical Staff member to understand how others have interpreted or received the behaviour;

###### provide supportive counselling either personally or through a third party, as appropriate;

###### in 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

###### prepare the summary documentation as set out above.

##### This process should be completed within 4 weeks of receiving the complaint if possible.

### Managing Unprofessional Behaviour or Failure to Meet Standards of Care: Stage Two Intervention

#### The Division Head, Department Head or Chief of Staff/Site-Medical Director shall follow the process set forth under Stage One Intervention.

#### The Division Head, Department Head or Chief of Staff/Site-Medical Director shall then work with the Medical Staff member to develop a contract between the Medical Staff member and VIHA, which will include the following:

###### method of redress (including but not limited to education, practice supervision, coaching, counselling, psychological or other medical testing, leadership training, substance use therapy, written project or tutorial sessions) 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;

###### method of monitoring for change/progress;

###### description of behaviour benchmarks;

###### time frame within which progress must be demonstrable; and

###### consequences for lack of progress or non-compliance.

#### The Division Head, Department Head or Chief of Staff/Site-Medical Director shall notify the Medical Staff member in writing that another incident 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 determined at that time.

### Managing Unprofessional Behaviour or Failure to Meet Standards of Care: Stage Three Intervention

#### The Division Head, Department Head or Chief of Staff/Site-Medical Director shall immediately inform the CMO and Chair of HAMAC who shall schedule a review of the complaint by the Discipline Subcommittee (DSC) of the HAMAC.

#### The DSC shall:

###### Review the behavioural and/or clinical care history of the Medical Staff member; and

###### Recommend other rehabilitation strategies or recommend disciplinary action as appropriate.

#### Disciplinary action that the DSC and HAMAC may recommend includes but is not limited to:

###### modification, suspension, revocation, or refusal to renew a Medical Staff member’s Privileges to practice within VIHA.

###### setting conditions, such as a requirement to complete a course or other remedial training, or a requirement to undergo an audit, or external reviews of the Medical Staff member’s practice.

#### Action on these recommendations shall follow the process outlined in Article 11.2 of the Bylaws.

### Managing Unprofessional Behaviour: Crisis Intervention

#### Where behaviour is too egregious or care deemed too unsafe to 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 summary suspension of Privileges as per Article 11.2 of the 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 the suspension as soon as circumstances permit.

#### 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.