MEDICAL STAFF RULES

FOR THE

VANCOUVER ISLAND HEALTH AUTHORITY

(ISLAND HEALTH)

DRAFT 11, VERSION 4

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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 attempts to document 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 Board of Directors 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 VIHA.
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 appointed by the Chief Executive Officer (CEO) of 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.
Chief of Staff (COS)	The hospital on-site Deputy of the CMO who is a member of the Medical Staff. The COS is responsible for the assurance of the quality of medical care and practice provided by members of the Medical Staff. The COS is appointed by the CMO in consultation with the local Medical Staff.
Credentialing	The process of screening and evaluating qualifications including appropriate training, licensure, experience, references, professional college requirements and practice insurance necessary for appointment to the VIHA Medical Staff.

Computerized Provider Order Entry (CPOE)	The process of order placement into the Electronic Health Record 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 Head	A member of the Active Medical Staff appointed by HAMAC on the advice of the CMO and Department Head Search Committee, and responsible to the CMO or CNO, as appropriate, to lead the clinical, academic, quality-improvement and governance activities of a Department.
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)	A secure, integrated, computerized collection of an individual's encounters with the health care system, which provides a comprehensive digital view of a patient's health history.
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 could be linked with other databases, such as an EHR.
Enhanced Medical Staff Support (EMSS)	An administrative team of Medical Affairs 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 the CMO, 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 member of the VIHA Medical Staff is an asset, but not a requirement. EMDs are required to abide by the VIHA Medical Staff Bylaws and Rules.
Facility	A health care Facility as defined by the Health Authorities Act.
Fellow	A physician who has completed an accredited specialist residency training program from a recognized university 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 that regulates the information and privacy practices of public bodies such as government ministries, local governments, crown corporations, 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 well as quality-of-care issues, as described in Article 8 of the Medical Staff Bylaws.
Health Record	A digital or hard-copy version of the patient medical chart.
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 managing 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 Department	A major component of the Medical Staff Organization established by Article 8 of the Bylaws and composed of matters with common clinical or specialty interest, which will advise and be accountable to HAMAC for the quality of patient care in that area of common clinical or specialty interest. All members of the medical staff must belong to, and fulfill the responsibilities of at least one Department.
Medical Director	An Active member of the Medical Staff who holds an Administrative role reporting directly to an Executive Medical Director.
Medical Lead	An Active member of the Medical Staff who holds an Administrative role reporting directly to a Medical Director.
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, Oral Surgeons, 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 component of the Medical Staff Organization, established by Article 11 of the Bylaws, to represent and advocate for the Medical Staff in general and to speak for the individual Medical Staff member in particular, and to bring matters of general concern to their LMACs and to HAMAC. All members of the Medical Staff must belong to, and fulfill the responsibilities of the Medical Staff Association.
Medical Staff Organization	The organization of the Medical Staff established by Article 2 of the Bylaws in a manner to be advisory and accountable, to the Board, through the HAMAC on matters of medical care of patients.
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 or Program.
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.
Procedure	All scheduled medical, surgical and interventional treatments or Procedures that are scheduled through VIHA booking services.
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.*
Regulatory College	The discipline-specific provincial 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 or Program owned or operated by VIHA.
Section	A component of a Division composed of members with clearly defined sub-specialty interests.
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.
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 meet a specific service need.
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 VIHA policy.

Article 1: Good Medical Practice

PREAMBLE

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 VIHA. 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 Board's obligation to patient care includes supporting the Medical Staff through the provision of adequate and appropriate resources.

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 VIHA. 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.

1.1 RESPECTFUL WORKPLACE POLICY

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

(i) Treated with dignity and respect, free from discrimination and harassment; and
(ii) Supported in the respectful management of workplace conflict.

1.1.2 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.

1.2 TRANSITIONS OF CARE & PATIENT SAFETY

1.2.1 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 or Program. 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.

1.2.1.1 The responsibility for patient care is outlined in Article 5 of the Bylaws. Only Medical Staff with Privileges to admit patients can be the MRP.

1.2.1.2 The MRP is the Practitioner responsible for the overall care of a patient admitted to a Facility or Program. The MRP works within a multidisciplinary team to deliver care and treatment to the patient.

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

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

1.2.1.5 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.

1.2.1.6 The MRP is responsible to:

(i) Accept patients for admission from the Emergency Department (ED) or following acceptance of a transfer-of-care request from another Practitioner;
(ii) Complete and document a full assessment for admission, including a full history, physical examination and orders for ongoing care;
(iii) Work collaboratively with team members to develop a Best Possible Medication History (BPMH), complete medication reconciliation and order appropriate medications;
(iv) Provide daily care for acute patients and care as appropriate for alternate-level-of-care (ALC) patients, completing progress notes and overseeing the patient's care, either directly or through an on-

call group. Responsibility for Long-Term Care patients is addressed in Article 3;

(v) Communicate with the patient and the patient's team members including 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;

(vi) Work collaboratively with healthcare team members;

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

(viii) Facilitate and coordinate discharge to the community and communication with the primary-care Practitioner, where possible, as well as with community support teams; and

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

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

1.2.2.1 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.

1.2.2.2 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.

1.2.2.3 If, at the time prior to accepting MRP but after personally 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.

1.2.2.4 Where an admission disagreement persists, the EP will 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, an Executive 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 will be reviewed by the appropriate Department Head(s), who will determine next steps to resolve the situation.

1.2.3 Most Responsible Practitioner for Care in Out-Patient Facilities or Programs

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

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

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

1.2.4 Consultations and Transfer of Care Within a Facility

1.2.4.1 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.

1.2.4.2 A consultation is a request for a professional opinion, advice or support in the management of a patient. The consultant will provide an in-person evaluation of the patient, a review of all necessary documentation and the provision of a timely, electronically-entered or dictated report. The evaluation should provide a clinical opinion, recommendations for management and/or treatment, and the basis for the advice given. The consulting Practitioner will notify the MRP on completion of the consultation in a timely and mutually acceptable manner.

1.2.4.3 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 will be documented 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, and other Practitioners involved in the patient's care and the multidisciplinary team, as appropriate.

1.2.4.4 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 will 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, electronically entered or verbal acceptance documented in the patient Health Record.

1.2.4.5 Reports

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

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

1.2.4.6 Urgency of Consultation

(i) To ensure timely information transfer and intervention, urgent (consultation within 12 hours) or emergent (consultation within 2 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.

1.2.5 Admission of Patients

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

1.2.5.2 Patients admitted for in-patient dental surgery by a member of the Dentistry staff will be admitted under the care of a Physician or Nurse Practitioner on the Active Medical Staff who will act as the MRP. For day-surgery dental procedures, a complete, up-to-date 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.

1.2.5.3 A complete medical history and physical examination is required for all admitted patients within 24 hours of admission. In VIHA facilities that have implemented the EHR, the history and physical must be entered into the EHR.

1.2.5.4 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 the EHR.

1.2.5.5 All readmissions require a full history and physical. The exception is planned readmissions for the same condition occurring within 28 days of discharge in which a copy of the previous admission history and physical exam and a new progress note may suffice. For unplanned readmissions, special attention should be paid to any factors,

including cognitive or functional issues that may have contributed to an unsuccessful discharge.

1.2.5.6 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 24 hours of the admission.

1.2.6 Transfer of Patients

1.2.6.1 The MRP will 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 will be duly recorded in the Health Record. This includes transfers to another Facility or Program. The MRP will inform the receiving site about the patient's condition and must be informed which Practitioner has agreed to accept MRP responsibility. The transfer will be followed by an expedited written or electronically entered or dictated summary from the transferring MRP. In the case of inter-Facility or Program transfers, the summary will accompany or precede the patient.

1.2.6.2 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.

1.2.6.3 Where a patient is transferred to another Facility or Program for administrative rather than medical reasons (e.g., lack of available beds at the sending Facility or Program), the MRP, if not assuming the MRP role at the new Facility or Program, will 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.

1.2.6.4 A capable patient or, if incapable, their legal representative, has the right to request a change of Practitioner. That Practitioner will 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 will 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.

1.2.7 Repatriation from a Higher-Level-of-Care Facility or Program to a Referring Facility or Program

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

1.2.7.2 Where repatriation occurs between two acute-care Facilities or Programs, 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.

1.2.7.3 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 the EHR, by entry into the EHR.

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

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

1.2.8 Discharge of Patients

1.2.8.1 Discharge planning should start from the time a patient is admitted until discharge. The MRP will document issues potentially impacting discharge options in the patient's Health Record within 24 hours of admission. The plan should be updated as part of daily care-planning.

1.2.8.2 The MRP or delegate on-call will provide a discharge order and complete a discharge summary using a discharge template approved by HAMAC. For detailed summaries and associated templates, the HAMAC-approved templates should be referenced. The discharge summary shall conform to the EHR documentation policy in Facilities where the EHR has been deployed. Incomplete or inaccurate discharge summaries can impact the ability to extract accurate patient data for improvement purposes.

1.2.8.3 A required component of the discharge process includes provision of follow-up instructions and a 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.

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

(i) An uncomplicated daycare or short-stay surgery or procedure;

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

1.2.8.5 For uncomplicated obstetrical admissions, the British Columbia (BC) Antenatal Record Part 1 and 2 or electronic equivalent with the EHR system will become an integral part of the patient record. The BC Labour and Birth Summary Record or electronic equivalent with the EHR system, 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.

1.2.8.6 A single report combining the operative report and discharge summary, including follow-up plans, is permitted for uncomplicated admitted surgical cases with a length of stay of less than 48 hours.

1.2.8.7 To ensure continuity of care and patient safety, the discharge summary should be dictated or electronically transcribed at the time of discharge but must be completed within the HAMAC-endorsed standard time, with the expectation that VIHA will ensure transcription within two (2) days following completion.

1.2.9 Reports

1.2.9.1 An operative report is required for all invasive procedures except those excluded by HAMAC. The report must be dictated or written or electronically entered within 24 hours upon completion of an operative or other high-risk procedure, but preferably immediately post-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).

1.2.9.2 The operative report must contain, at a minimum:

(i) The patient's name and Health Record number;
(ii) The name of the primary surgeon and assistant(s);
(iii) The names of Practitioners who should receive a copy of the report;
(iv) Date and time of admission;
(v) Date of procedure;
(vi) Pre-operative and post-operative diagnosis;
(vii) Proposed procedure(s) and indications;
(viii) Operative procedure(s) performed;
(ix) Operative complications, if any;
(x) The patient's condition before, during and immediately after the operation;
(xi) Estimated blood loss; and
(xii) Specimens removed and their disposition (e.g., to pathology).

1.2.9.3 For medical-imaging and laboratory-medicine procedures, or where HAMAC has deemed an operative report is not required, a procedure note is required in lieu of an operative report.

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

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

1.3 ON-CALL

1.3.1 On-call coverage for admitted patients

1.3.1.1 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.

1.3.1.2 Groups of Practitioners with a similar scope of practice may join together in call-groups to share the requirements of their patients'care. These Practitioners will create an on-call rota to ensure 24-hour coverage for the group's in-patients in a manner acceptable to their Department of Division and the CMO.

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

(i) Emergency-Department (ED) patients who require urgent consultation or in-patient admission; and
(ii) Patients already admitted to hospital whose condition necessitates urgent intervention or consultation by a Practitioner other than the MRP.

1.3.1.4 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.

1.3.1.5 Department members may request access to finite Health Authority resources in order to practice. Access to these resources will be allocated on an equitable basis, taking into consideration the Department members' contribution to the Department and Health Authority. Such contributions include, but are not limited to, the provision of on-call coverage.

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

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

1.3.1.8 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.

1.3.1.9 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).

1.3.1.10 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.

1.3.1.11 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.

1.3.2 On-call scheduling

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

(i) Provide a Practitioner available to assess and treat the patient(s) at all times;
(ii) Be maintained in up-to-date fashion at all times;
(iii) Identify the Practitioner by name, including up-to-date expedited contact information;
(iv) Identify the Practitioner responsible for maintaining the on-call list, including contact information;
(v) Be made available in a manner, time and format acceptable to VIHA in order to distribute it to necessary recipients; and
(vi) 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 distributed in advance to all necessary recipients.

1.3.2.2 The frequency of call is determined by both the needs of the patients served by the call group and by the size of the on-call group. Consideration will be given to the intensity of call responsibilities to ensure that the combination of frequency and intensity of call does not compromise the safety of patients and or Medical Staff and the sustainability of the call group. In the event of an unresolved dispute of call frequency, the matter will come before HAMAC.

1.3.2.3 On-call Practitioners will maintain availability dictated by the patient's condition and clinical requirements.

1.3.3 On-call exemptions

1.3.3.1 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.

1.3.3.2 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 will exercise all means available to find a replacement.

1.3.3.3 The Department Head, in consultation with the Division Heads and Department members, will 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.

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

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

1.3.3.5 The Department Head will 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.

1.4 Health Records / Documentation and Order Management

1.4.1 Both paper-based and Electronic Health Records are those documents compiled by the medical and professional staff of VIHA to document care provided to patients, clients and residents. Practitioners are responsible to complete their component of a Health Record regardless of the format in which the Health Record is maintained.

1.4.2 Medical Staff will use Computerized Provider Order Entry (CPOE) to place, manage and monitor orders electronically in the EHR where CPOE has been implemented. VIHA is responsible to provide education and training for the use of CPOE and the EHR. These policies are outlined here.

1.4.3 Orders for Medical Treatment

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

1.4.3.2 An order for medical care may be dictated over the telephone to a registered nurse, licensed practical nurse or registered psychiatric nurse. An order dictated over the telephone will be documented over the name of the ordering Practitioner by the person to whom the order is dictated. The ordering Practitioner must ensure the order is co-signed in the paper Health Record or co- signed in the EHR within 24 hours of the order having been dictated.

1.4.3.3 A Practitioner may give telephone orders to other professional staff such as medical imaging and laboratory technologists, occupational therapists, physical therapists, respiratory therapists, dietitians, social workers, or pharmacists, who will 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.

1.4.3.4 Paper-based orders may be faxed if they are signed by the practitioner.

1.4.3.5 In an emergency a Practitioner may give verbal orders to other members within the scope of practice of the care team providing individuals receiving these orders have them within their scope of practice. They will document and sign the order on behalf of the Practitioner. Following the emergency situation, the ordering Practitioner will countersign these orders as soon as possible. In Facilities or Programs where CPOE is initiated, the Practitioner will ensure the orders are entered into the EHR and signed by the ordering Practitioner.

1.4.3.6 Orders will 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 will 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.

1.4.3.7 Medication orders will follow the standards outlined in the VIHA Medication Orders Management policy . Orders will be legible, accurate, contain only approved abbreviations, and adhere to VIHA's formulary policies.

1.4.3.8 Practitioners prescribing medication will comply with Section 19 of the Controlled Drugs and Substances Act (1996) and other federal and provincial legislation pertaining to the use of drugs.

1.4.3.9 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.

1.4.3.10 A Practitioner using Clinical Order Sets, whether pre-printed or electronically available in the EHR, is responsible for signing them.

1.4.4 Progress Notes

1.4.4.1 Progress notes for patients designated Acute will be documented by the MRP at least daily, or more frequently if warranted by the evolving condition of the patient.

1.4.4.2 Progress notes for ALC patients must be documented at least weekly and more frequently in response to a change in the patient's condition.

1.4.4.3 Progress notes will document:

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

1.4.5 Completion of Health Records

1.4.5.1 Health Records containing all relevant documents should be completed and validated by all involved Practitioners as soon as they become available. All Practitioners will comply with the VIHA Clinical Documentation Policy approved by HAMAC and the Board.

1.4.5.2 The Health Record may be filed as incomplete only under the following extenuating circumstances:

(i) Medical Leave of Absence greater than three months;
(ii) Resignation from the VIHA Medical Staff;
(iii) Retirement; and
(iv) Death of Medical Staff member.

1.4.5.3 If the MRP is no longer available to complete the Health Record(s) due to circumstances outlined in Article 1.3.5.2 above, the appropriate Division Head, Department Head or Chief of Staff will review the record and provide written authorization to file the Health Record as incomplete.

1.4.5.4 If the Practitioner is unable to complete and validate the Health Record because all relevant documents and reports are not available or completed, the Practitioner will notify the Health Records Management Department directly.

1.4.5.5 Prior to planned absences, the Practitioner will complete all outstanding Health Records. In unplanned absences, outstanding records will be completed within 14 days of the Practitioner's return.

1.4.5.6 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.

1.4.5.7 The Health Records Management Department will provide the responsible Practitioner

with written notification of incomplete Health Records. The Practitioner will complete the identified records within the HAMAC-approved VIHA time from 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 will result in an administrative suspension of all Privileges except that the Practitioner will continue to provide ongoing care for patients already admitted to hospital and to fulfill medical department on-call obligations until the records are complete.

1.4.5.8 After a Practitioner receives three automatic suspensions in any consecutive 12-month period, HAMAC will review the circumstances and may impose a full suspension for up to 30 days.

1.4.6 Release of Health Records

1.4.6.1 VIHA has a legal obligation to protect health information. The information belongs to the Patient but VIHA is the legal custodian of the Health Record. Original or copies of Health Records are not to be removed from a Facility or Program unless authorization is received from VIHA Health Information Management, or unless in compliance with a legally valid Subpoena Duces Tecum or a legally valid Search Warrant.

1.4.6.2 Paper Health Records may travel with the patient, family or caregiver during the provision of care.

1.4.6.3 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.

1.4.6.4 Confidentiality of patient medical information is of utmost importance. Practitioners will adhere to:

(i) Federal or provincial legislation governing privacy and access to Health Records; and
(ii) VIHA policies governing privacy and access to Health Records.

1.4.6.5 All Staff have a duty of confidentiality to patients. FOIPPA 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.

1.5 MEDICAL STAFF MEMBERSHIP AND PRIVILEGES

1.5.1 Terms and criteria for appointment and membership are detailed in Article 3 of the Bylaws. Procedures for application, appointment and review are detailed in Article 4 of the Bylaws. VIHA supports consistency and transparency in these processes.

1.5.2 Procedure to Address Application Requests when No Medical Staff Vacancy Exists

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

1.5.2.2 Unsolicited letters of intent to apply for membership on the Medical Staff where a vacancy does not exist should be forwarded to Medical Affairs expediciously for appropriate review and management.

1.5.2.3 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.

1.5.3 Appointment to the Medical Staff

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

1.5.3.2 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.

1.5.3.3 Site-specific Privileges convey no preferential status for Privileges in any other Facility or Program operated by VIHA.

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

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

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

1.5.3.5 The Department Head, or delegate, will 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.

1.5.3.6 Each Practitioner will be assigned to a Primary Department. HAMAC will 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.

1.5.3.7 A Provisional, 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.

1.5.3.8 The process for specialist recruitment to the Medical Staff is defined in VIHA Policy #3.1.2: Specialist Physician Recruitment. The appointment of a specialist requires completion of a VIHA Impact Analysis and is governed by Article 3.1.5 of the Bylaws.

1.5.4 Medical Staff Categories

1.5.4.1 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:

(i) Provisional staff;
(ii) Active staff;
(iii) Associate staff;
(iv) Consulting staff;
(v) Temporary staff;
(vi) Locum tenens staff;
(vii) Scientific and Research staff; and
(viii) Honourary staff.

1.5.5 Locum Tenens Staff

1.5.5.1 Article 6.6 of the Bylaws defines the Locum Tenens Staff category and scope of practice. For better clarity these Rules define privilege activation or de-activation, maintenance of Privileges and responsibilities for Locum Tenens Staff, as well as the role of Provisional, Active or Consulting Staff members seeking a Locum Tenens.

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

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

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

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

1.5.5.6 While Locum Tenens Staff Privileges may be granted for up to twelve months, each

activation of locum coverage must be approved in advance in order to activate Privileges. When the approved period of coverage concludes, Privileges are deactivated. For each subsequent locum-tenens coverage period a Provisional, Active or Consulting Staff member must submit a completed locum scheduling form to the Credentialing & Privileging Office confirming coverage dates, which then must be approved by the Division or Department Head prior to privilege re-activation.

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

1.5.6 Application & Maintenance of Locum Privileges

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

1.5.6.2 Minimum lead times for Locum Tenens category Privileges are:

(i) New Applicants: six (6) weeks
(ii) Current Locum Tenens Staff requesting additional site Privileges: two (2) to four (4) weeks.

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

1.5.6.4 Upon approval by the Division or Department Head, applicants who have not previously held VIHA Medical Staff Privileges will be provided an application package for new Locum Tenens Privileges. The completed application package must be approved by the Division or Department Head, following which it will be forwarded to MPCC and HAMAC for a recommendation to the Board for approval.

1.5.6.5 Performance appraisals will be completed in accordance with guidelines.

1.5.7 Responsibilities of the Medical Staff Member Requesting a Locum Tenens

1.5.7.1 The Medical Staff member is responsible to notify the Credentialing & Privileging Office of an upcoming Locum Tenens arrangement by forwarding the completed locum scheduling form, indicating start and end dates, within the required minimum lead time.

1.5.7.2 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.

1.5.7.3 The Medical Staff member is responsible to arrange the orientation of the Locum Tenens Practitioner to the Facility or Program, 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

will assign the responsibility to another member of the Medical Staff.

1.5.7.4 In facilities where EHR has been implemented, Medical Affairs must facilitate timely VIHA-approved EHR competency training and advise the Locum Tenens Practitioner of this requirement.This training must be completed before Privileges will be activated.

1.5.7.5 The Medical Staff member is responsible for the completion of any Health Records the Locum Tenens Practitioner fails to complete while providing locum-tenens coverage.

1.5.8 Responsibilities of Locum Tenens Practitioner

1.5.8.1 Locum Tenens Privileges are granted to a specific Physician for a defined period of time.

1.5.8.2 VIHA will ensure that the prospective Locum Tenens has access to adequate EHR training and in turn the new Locum Tenens must ensure EHR education training has been completed and competency has been achieved. Failure to do so may result in not receiving Privileges in time to cover the desired locum.

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

1.5.8.4 Locum Tenens Staff may not assign their locum coverage to another Practitioner with Locum Tenens Privileges.

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

1.5.9 Temporary Staff

1.5.9.1 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.

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

1.5.9.3 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 CMO, on the authority of the CEO, may grant Temporary Privileges for a specified purpose and period of time. Examples include:

(i) Privileges required for organ retrieval;
(ii) Demonstrating equipment or new procedures;
(iii) Providing care during mass casualties; or

(iv) Meeting a time-limited clinical need that temporarily overwhelms a Department's capacity to provide adequate coverage.

This Appointment will be ratified or terminated by the Board at its next scheduled meeting.

1.5.10 Interim Appointment

1.5.10.1 Interim Appointment is a term used by the VIHA HAMAC, MPCC and Medical and Academic Affairs Department to describe Privileges granted to an applicant whose clinical services are required while an application is still proceeding through the approval process, which is outlined in Article 4 of the Bylaws.

1.5.10.2 When circumstances require Privileges to practice in a Facility or Program operated by VIHA before a final application can be reviewed by HAMAC and approved by the Board, the CMO may grant an Interim Appointment to the Medical Staff. The MPCC or it's delegate 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 4.1.3 of the Bylaws.

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

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

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

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

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

1.5.10.8 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.

1.5.10.9 In the event that the Board does not approve the Appointment of an applicant with an Interim Appointment, the applicant will 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.

1.5.11 Clinical Fellows

1.5.11.1 Appointments: Clinical Fellows are physicians who have applied to and been accepted by VIHA for further training in a clinical discipline. They must have medical

liability insurance acceptable to VIHA, be licensed by the College of Physicians & Surgeons of British Columbia and be registered with the Faculty of Medicine at the University of British Columbia. Clinical Fellows will be accepted only if supported by the appropriate Department Head, recommended by HAMAC and approved by the Board. This process is congruent with the requirements for an appointment to the Medical Staff.

1.5.11.2 Scope of Practice: Clinical Fellows may attend patients under the supervision of a member of the Active, Provisional, Consulting or Locum Medical Staff of the department responsible for supervision of their work in Facilities operated by VIHA. They may carry out such duties as are assigned to them by the Head of the Department or delegate to whom they have been assigned. Although they may complete the admission evaluation, patients must be admitted under their supervising medical staff member. They may not vote at Medical Staff or Department meetings.

1.5.12 Clinical Trainees

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

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

1.5.13 Students

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

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

(ii) All electives that are part of UBC designated programs must be approved and registered through the applicable clinical Faculty at the University of British Columbia. Students applying outside of these UBC designated positions must make application as outlined in the procedures of the appropriate regulatory body and be licensed by that body, or where educational license provisions do not exist, must comply with Island Health policies for the involvement of trainees in clinical work in that discipline.

(iii) Approval of an elective may also be subject to other considerations, such as the ability of the clinical environment to accommodate another trainee.

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

(v) Students will not sign certificates of death.

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

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

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

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

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

1.5.14 Leave of Absence

1.5.14.1 An absence from Medical Staff practice for a period between eight (8) weeks and twelve (12) months is considered a Leave of Absence (LOA). Each LOA requires approval by the Board as outlined in Article 4.7.1 of the Bylaws. Maternity or Paternity Leave requires notification to the Board.

1.5.14.2 Requests for Medical Leave need to be supported by the relevant medical documentation.

1.5.14.3 Where the LOA was granted for medical reasons or because a Practitioner's

registration status has been changed to Temporarily Inactive by the applicable College, the CMO must receive acceptable supporting documentation that the Practitioner is fit to resume Privileges to practice in VIHA. This may require a report from an independent medical Practitioner. The documentation will include what restrictions, if any, apply to the resumption of Privileges. The Practitioner has the right to appeal the CMO's decision through HAMAC to the Board.

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

1.5.15 Reappointment to the Medical Staff

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

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

1.5.16 Maintenance of Current Practitioner Information

1.5.16.1 Practitioners will inform Medical and Academic Affairs 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.

1.5.16.2 Practitioners will keep the 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).

1.5.17 In-Depth Practitioner Reviews

1.5.17.1 Periodic reviews are meant to be a collaborative, positive approach to professional growth and development. The ultimate goal with periodic reviews is to provide Practitioners with objective data and feedback 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.

1.5.17.2 In-depth reviews are used primarily when considering moving a Practitioner from Provisional to Active Staff category, or for Locum Tenens completing the first six (6) to twelve (12) months of service. They are 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.

1.5.17.3 The recommended format of the periodic performance review is based on the CanMEDS Framework and will include a self-assessment to be completed and brought 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.

1.5.17.4 The practice and performance review may be completed by:

(i) A Department Head
(ii) A Division Head
(iii) The Chief of Staff of the local Facility, or
(iv) An external reviewer, approved by the HAMAC on the recommendation of the Department Head, Executive Medical Director or CMO.

1.5.17.5 The Department Head or delegate will 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.

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

1.5.18 Mid-Term Changes to Privileges

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

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

2 Organization of the Medical Staff

2.2 Medical and Academic Affairs (MAA)

2.2.1.1 Medical and Academic Affairs is the administrative department responsible for supporting the Medical Staff Organization and its leaders by developing and implementing policies and procedures that support:

(i) Effective recruitment;
(ii) Credentialing and privileging;
(iii) Onboarding and orientation;
(iv) Quality and performance improvement;
(v) Medical Staff governance;
(vi) Contract management and remuneration and;

(vii) Continuing professional development
(viii) Medical Staff wellness and resilience

2.3 Organization of the Medical Staff

2.3.1 VIHA maintains a medical leadership structure in support of governance and clinical operations of the Health Authority. A description of the current structure can be found here.

2.3.2 In accordance with Article 8 of the Bylaws, the Board, upon the advice of the HAMAC, will organize the Medical Staff into Departments, Divisions and Sections.

2.3.3 All members of the Medical Staff will belong to at least one Department and maintain Privileges in at least one site, as outlined in Article 1.5.3.6 of these Rules.

2.3.4 Departments

2.3.4.1 The Medical Staff Departments in VIHA will be:

(i) Pathology and Laboratory Medicine;
(ii) Imaging Medicine;
(iii) Medicine;
(iv) Psychiatry;
(v) Maternity Care & Pediatrics;
(vi) Primary Care;
(vii) Surgery;
(viii) Anesthesiology, Pain & Perioperative Medicine; and
(ix) Emergency & Critical Care Medicine.

2.3.4.2 Departments are Health-Authority wide structures. The scope of academic and clinical activity is specific to each site.

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

2.3.4.4 Departments will be responsible for monitoring the quality of patient care and services provided by their members. Department members will participate in a program of structured quality assurance, including Morbidity and Mortality rounds and case reviews arising from Quality Committee activities or complaints, regarding the care provided to patients by its Members. These programs will at minimum include:

(i) Patient clinical outcomes;
(ii) Legislatively mandated reviews;
(iii) Adverse clinical events arising from patient care; and
(iv) Mortality in acute care environments

2.3.5 Divisions

2.3.5.1 Departments may be further organized into Divisions.

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

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

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

2.3.5.5 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.

2.3.6 Sections

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

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

2.3.7 Meetings

2.3.7.1 Each Department will meet at the call of the Department Head to address matters of importance to the department.

2.3.7.2 Department Heads will meet with their Division Heads a minimum of four (4) times per year.

2.3.7.3 Each Division will 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 mandate.

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

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

2.3.7.6 Active Members of Medical Staff are required to attend at least 60% of primary departmental/divisional meetings. In the event that a member is unable to meet this requirement, there will be discussion between the Medical Staff Member and the Division Head regarding how this requirement will be fulfilled in the future.

2.3.7.7 Departmental Leadership meetings will follow the meeting governance and operations processes as outlined in Article 2.6.1 to 2.6.8 of these Rules.

2.4 Medical Staff Departmental Leadership

2.4.1 Department, Division and Section Heads provide assurance of public safety by ensuring each Practitioner is duly qualified and privileged to provide care and that the quality of care meets an acceptable standard.

2.4.1.1 Physician-leadership oversight roles encompass:

(i) Standards of Care and documentation;
(ii) Recruitment;
(iii) Resource planning;
(iv) Privileging;
(v) Performance monitoring & improvement;
(vi) Education and research;
(vii) Professional Competence and Behaviour;
(viii) Individual Provider Quality; and
(ix) Medical Staff wellness

2.4.2 Department Heads

2.4.2.1 The responsibilities of the Department Head are outlined in Article 8.2 of the Bylaws.

2.4.2.2 The Department Head has VIHA-wide responsibilities.

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

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

2.4.2.5 Where a Department Head vacancy exists, the CMO and HAMAC will strike a a search committee. Members of the HAMAC and the applicable Department will be represented on the committee.

2.4.2.6 The search committee will act in an advisory role to the CMO, the HAMAC and the Board.

2.4.2.7 Following the search process, the Department Head will be appointed by the Board upon the recommendation of the CMO and HAMAC after considering the advice of the search committee.

2.4.2.8 The Department Head reports to and is accountable to the CMO.

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

2.4.2.10 The Department Head will identify an Assistant Head to assume the responsibilities of the role in the Department Head's absence.

2.4.2.11 In addition to those duties outlined in Article 8.2 of the Bylaws, the Department

Head will:

(i) Ensure the department has relevant practice standards and ensure that those standards are used as part of practice assessments;
(ii) Monitor and anticipate Department workforce needs, and collaborate with Medical and Academic Affairs to help address those needs through effective recruitment;
(iii) Lead the implementation of procedures to support Department members to participate in medical education and research;
(iv) Ensure the Department workforce plan provides sufficient staff to meet clinical requirements while accommodating medical-education and research activities;
(v) Monitor and facilitate improved quality of practice for individual Department members;
(vi) Collaborate in the development of a robust Medical Staff Human Resource Plan .
(vii) Attend to Credentialing and Privileging requirements;
(viii) Implement a process for periodic in-depth Practitioner review;
(ix) Oversee Continuing Professional Development (CPD), including implementation of an annual CPD plan for the Department; and
(x) Collaborate with the Enhanced Medical Staff Support (EMSS) team to support the development and maintenance of positive Departmental relationships and working environments.

2.4.2.12 The CMO will be responsible for conducting a regular performance review of each Department Head.

2.4.2.13 In the final year of a Department Head's term, a committee will be struck to review and provide recommendations regarding future appointment.

2.4.2.14 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 will be given to the Department Head, the CMO and the HAMAC.

2.4.2.15 If a Department Head resigns or is removed, the Assistant Department Head will 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.

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

2.4.2.17 The term of appointment for a Department Head will be three (3) to five (5) years, renewable up to a maximum of ten (10) years.

2.4.3 Division Head

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

2.4.3.2 Division Heads may have cross-Facility responsibilities.

2.4.3.3 The Division Head will be an Active Staff member of the Division who provides governance and leadership to Division membersas outlined in the Bylaws and Rules

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

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

2.4.3.6 The Division Head collaborates with the Department Head to ensure the quality of clinical services by Practitioners within the Division meets an acceptable standard.

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

2.4.3.8 The term of appointment for a Division Head will be three (3) to five (5) years, renewable up to a maximum of ten (10) years.

2.4.4 Section Head

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

2.4.4.2 Section Heads may have cross-Facility responsibilities.

2.4.4.3 The Section Head is an Active Staff member of the Section who provides governance and leadership to Section members as outlined in the Bylaws and Rules.

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

2.4.4.5 The Section Head will be appointed by the Division Head after consultation with Section members.

2.4.4.6 The Section Head collaborates with the Division Head to ensure the quality of clinical services by Practitioners within the Section meets an acceptable standard.

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

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

2.4.4.9 The term of appointment for a Section Head will be three (3) to five (5) years,

renewable up to a maximum of ten (10) years.

2.5 Medical Staff Association

2.5.1 Health Authority Medical Staff Association (HAMSA)

2.5.1.1 The HAMSA is a VIHA-wide entity operating in accordance with Article 10 of the Bylaws and consists of all members of the Medical Staff.

2.5.1.2 The functions and duties of HAMSA are considered fulfilled by the Local Medical Staff Associations (LMSAs) and the HAMSA Executive Committee (HEC) which are:

(i) To represent the views of its members both individually and collectively;

(ii) To raise regional matters and communicate on behalf of the Medical Staff to the HA Administration and the Board.

2.5.2 HAMSA Executive Committee (HEC)

2.5.2.1 This Committee is responsible to the Medical Staff of VIHA.

2.5.2.2 The HAMSA Executive Committee is composed of all LMSA Presidents and one other executive member of each LMSA. Three committee members will be elected as officers (Chair, Vice-chair & Secretary) of HEC where officers serve for a one (1) year term renewable up to a maximum of three (3) consecutive years in office.

2.5.2.3 The functions of HEC are:

(i) To represent the collective voice of the Medical Staff members;
(ii) To advise the HAMAC and VIHA of the concerns, opinions and regional issues of common interest of its members and advocate on their behalf; and
(iii) To provide a forum for LMSAs to discuss issues and develop regional initiatives of mutual interest.

2.5.2.4 The HAMSA Executive Committee will annually elect one member to sit on HAMAC as a voting member, in addition to the 4 LMSA representatives.

2.5.2.5 HEC meetings will be held at the call of the HAMSA executive, with at least one annual meeting. Quorum will consist of at least 1 officer and 3 other HEC members with minimum representation of 4 LMSAs.

2.5.3 Local Medical Staff Association (LMSA)

2.5.3.1 The Local Medical Staff Associations consist of all privileged Medical Staff at a local site and will operate in support of the HAMSA.

2.5.3.2 The functions of the LMSA are:

(i) To provide voice to the Medical Staff and to represent the views of its local members both individually and collectively;
(ii) To provide a forum to inform and connect the Medical Staff on issues of importance to its members;
(iii) To raise regional matters or matters of significance to the Medical Staff with administration and HAMAC;
(iv) To engage members of the Medical Staff locally on program and resource planning; and
(v) To foster effective communication among the Medical Staff and local site administration including physician and non-physician leaders.

2.5.3.3 The duties of the LMSAs are:

(i) The LMSA president or delegate sits as a voting member of the LMAC and LQOC at facilities within the jurisdiction of the LMSA;
(ii) The executive will appoint a candidate to temporarily fill any position vacated during the term of office until the next Annual General Meeting;
(iii) The LMSA will prepare a list of candidates for the LMSA Executive for presentation at the annual meeting of the Medical Staff Association;
(iv) The LMSA will notify the Medical Staff 30 days prior of upcoming elections and ensure a process to receive nominations for officer positions;
(v) Ensure a fair and equitable system of voting; and
(vi) To collect dues where approved by the members at the Annual General Meeting.

2.5.4 The officers of LMSA Executive will consist of:

(i) President;
(ii) Vice-President; and
(iii) Treasurer

2.5.4.1 Officers will be elected on an annual basis and may serve for a maximum of six consecutive years in a particular office.

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

2.5.4.3 To prevent the perception or allegation of conflict of interest, LMSA Officers will not simultaneously hold a VIHA leadership role as Medical Director, Medical Lead, Department Head, Division Head or Section Head. However, facilities with limited physician resources can hold dual positions and steps will be taken to declare and mitigate conflicts of interest.

2.5.5 LMSA Meetings

2.5.5.1 Meetings of the LMSAs will be held at least once per year and at the call of the LMSA Executive. There will be an Annual General Meeting for the purpose of facilitating discussions, reviewing financials and to hold elections as necessary for officer positions.

2.5.5.2 The LMSAs will invite the CEO and the CMO or their delegates to attend the Annual General Meeting.

2.5.5.3 A Special meeting of the LMSA may be called at the request of the LMSA Executive or 10% of the membership of the LMSA with a minimum of 72 hours' notice.

2.5.5.4 Notice of Special meeting must identify the business to be discussed and no other business will be transacted in the meeting.

2.5.5.5 Notification of a regular meeting must be given at least fourteen (14) days before the meeting. An agenda will be circulated no later than seven (7) days before the meeting.

2.5.5.6 Medical Staff members are requested 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.

2.5.5.7 Members present at the meeting will constitute quorum.

2.6 Medical Staff Committees

General Principles of Governance and Operation:

2.6.1 A simple majority of voting members (50% +1) will 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.

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

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

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

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

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

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

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

2.6.9 Health Authority Medical Advisory Committee

2.6.9.1 Purpose and Responsibilities

2.6.9.2 The HAMAC is the senior advisory committee of the Medical Staff as defined in Article 9 of the Bylaws.

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

(i) Appointment and review of members of the VIHA Medical Staff, including the delineation of clinical and procedural Privileges;
(ii) The quality, effectiveness, and availability of medical care provided within VIHA Facilities and Programs;
(iii) The establishment and maintenance of professional standards in Facilities and Programs operated by VIHA in compliance with all relevant legislation, the Bylaws, Rules and policies;
(iv) 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;
(v) Continuing Professional Development (CPD) of the Medical Staff;
(vi) The professional and ethical conduct of members of the Medical Staff; and
(vii) Disciplinary measures for violation of the Bylaws, Rules and policies governing the conduct of the Medical Staff.

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

2.6.9.5 Appointments to HAMAC:

(i) The Chair and Vice-Chair of the HAMAC are appointed by the Board on the recommendation of the HAMAC and the CMO.
(ii) The Chair and Vice-Chair will 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.

2.6.9.6 Voting Members:

(i) Chair of the HAMAC
(ii) Vice-Chair of the HAMAC
(iii) Vice President Medicine, Quality and Academic Affairs
(iv) Each VIHA Department Head or delegate
(v) One (1) LMAC Chair from each of the four geographies
(vi) One (1) MSA representative from each of the four geographies
(vii) One (1) MSA member at large, as nominated by the MSA Presidents
(viii) Chief Medical Health Officer
(ix) Chief Medical Information Officer

2.6.9.7 Non-voting Members:

(i) President and CEO
(ii) All Executive Medical Directors of Island Health
(iii) HAMAC standing subcommittee Chairs
(iv) General Legal Counsel & Chief Risk Officer
(v) Executive Vice-President, Quality, Safety & Experience
(vi) Other members of the senior administrative or Medical Staff of VIHA as appropriate and as agreed between the HAMAC Chair and CMO.
(vii) Patient Partner(s)

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

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

2.6.9.10 The Executive Committee will 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.

2.6.9.11 The executive committee will be comprised of:

(i) Chair of the HAMAC
(ii) Vice-Chair of the HAMAC
(iii) Chief Medical Officer
(iv) One (1) MSA representative who is a voting member on the HAMAC
(v) Two (2) Department Heads

2.6.9.12 Regular Meetings

The HAMAC will 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:

(i) The agenda and related material will be distributed to the membership not less than one week before any regular meeting.
(ii) 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.
(iii) There is no maximum term for voting, non-voting and executive members of the HAMAC.
(iv) HAMAC voting members are expected to attend all HAAMC meetings in person or by proxy. If a proxy is used, the HAMAC Member is responsible for ensuring that proxy is prepared for the meeting. The proxy will be authorized to vote on the member's behalf.

2.6.9.13 Special Meetings

(i) 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.
(ii) A minimum of four days' notice is required for special meetings. Exceptions can be made at the discretion of the HAMAC Chair in consultation with the CMO in extraordinary circumstances. The rationale for the exception will be provided to HAMAC and the Board at their next meetings for their consideration.
(iii) 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.

2.6.9.14 Organizational Meeting

(i) Annually, the HAMAC will 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.
(ii) In compliance with the Bylaws, a video-conference meeting will be construed as a face-to-face meeting.
(iii) Quorum for the organizational meeting will be a simple majority of the regular HAMAC voting membership.
(iv) The meeting will be for the purpose of receiving reports and confirming membership of the HAMAC and its' subcommittees. Standing subcommittee reports will include, at a minimum, work completed over the previous year, and goals for the coming year.

2.6.9.15 Role and Responsibilities of the HAMAC Chair

2.6.9.16 The Chair:

(i) Acts as the principle spokesperson for the HAMAC in liaising with the CEO, the CMO and the Board of Directors;
(ii) Chairs meetings of the HAMAC and if unable to attend, delegates this role to the Vice Chair.
(iii) Manages the affairs of the HAMAC between meetings, ensuring that committee responsibilities are discharged in a timely manner;
(iv) Oversees the secretariat in coordinating and ensuring timely reporting by the subcommittees to HAMAC;
(v) Serves as an ex-officio member of all HAMAC subcommittees;
(vi) Oversees the annual confirmation of the HAMAC membership and appoints subcommittee Chairs;
(vii) Communicates broadly to the Medical Staff on business decisions, motions and advice provided by the HAMAC;
(viii) Reports to and attends meetings of the Board of Directors; and
(ix) Performs other duties relevant to HAMAC as requested by the CEO or the Board.

2.6.9.17 Local Medical Advisory Committees (LMACs)

(i) The LMAC is a site-specific sub-committee of the HAMAC that fulfills the same duties and functions as HAMAC at the local level. It is usually chaired by the Chief of Staff and Site Medical Director but may be chaired by another member of the local Medical Staff. The LMAC will report to the HAMAC on its minuted business and approved motions, and bring reports and requests for action or consultation to the LMAC from HAMAC.

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

(iii) Where governance of the Medical Staff would benefit from a more regional approach, a LMAC structure may be created to serve multiple facilities in a region or coordinate the activities of individual site LMACs.

(iv) The LMAC is the body responsible for initial review of requests for Privileges at the site or sites within its jurisdictions. LMAC will examine such applications in camera under the protection of Section 51 of the Evidence Act, including reports from referees, prior to making a recommendation on the approval of Privileges to HAMAC through the MPCC.

(v) The LMAC functions as a recognized quality committee and may hear quality assurance matters in camera under protection of Section 51 of the Evidence Act. Any such discussions will be summarized and reported to HAMQC.

(vi) The LMAC will review and make recommendations on the local Medical Staff Human Resource Plan , including making recommendations on Recruitment to the MPCC.

(vii) The LMAC will be responsible for the creation of search committees to fill local Medical Staff vacancies, in collaboration with the relevant Department and in compliance with applicable Island Health policies.

(viii) The LMAC will work with site leadership and the Local Quality and Operations Council (LQOC) to support Medical Staff engagement in site operations, occupational health and safety, quality improvement and quality assurance.

(ix) LMAC may strike other subcommittees to address site(s) specific issues relevant to its mandate.

2.6.9.18 Voting Members:

(i) If not the Chair, the Chief of Staff retains voting membership on the LMAC

(ii) The President of the site(s) MSA

(iii) All Division Heads. Division Heads not present at a site may delegate their responsibility to a local Member of the Medical Staff (often this delegate will be a Medical Lead)

(iv) A representative(s) of the local Division(s) of Family Practice as deemed appropriate by the LMAC. To be a voting member the representative must have Active Privileges

2.6.9.19 Non-Voting Members:

(i) Other site-specific members of the Medical Staff or Island Health administration as deemed appropriate by the chair

(ii) Geography Executive Medical Director and Executive Director

2.6.9.20 Frequency of LMAC Meetings

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

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

(1) Cowichan District Hospital

(2) Lady Minto Gulf Islands Hospital
(3) Nanaimo Regional General Hospital
(4) North Island Hospital (Campbell River Hospital and Comox Valley Hospital)
(5) Saanich Peninsula Hospital
(6) South Island Tertiary Hospitals (Victoria General Hospital and Royal Jubilee Hospital)
(7) Tofino General Hospital
(8) West Coast General Hospital

(iii) Other LMAC committees may be formed by decision of the Board upon the recommendation of HAMAC

2.6.9.21 Standing Subcommittees

2.6.9.22 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.

2.6.9.23 Chair and Vice-Chair Appointments to Standing Subcommittees

(i) The Chair of the standing subcommittee is appointed by the HAMAC from eligible members of the Medical Staff.
(ii) The Chair is appointed for a term of not more than three (3) years and may remain in the position for up to three (3) consecutive terms, for a total of nine (9) years.
(iii) A Vice-chair is appointed by the Chair of the standing subcommittee and is selected from the voting membership of that standing subcommittee.
(iv) The Vice-chair of the standing subcommittee is appointed for a term of not more than three (3) years and may remain in the position for up to three (3) consecutive terms, for a total of nine (9) years.

2.6.9.24 Role and Responsibilities of Chair of Standing Subcommittees

2.6.9.25 The Chair will:

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

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

2.6.9.27 Medical Planning and Credentials Committee (MPCC)

2.6.9.28 Purpose and Responsibilities

(i) The MPCC functions as the Credentials Committee for the Health Authority. Its role is outlined in Article 4.3 of the Bylaws.

(ii) The MPCC is responsible for reporting and making recommendations to the HAMAC on:
(Medical Staff recruitment;
(1) Credentialing, privileging, appointment and reappointment;
(2) Medical Staff performance review and;
(3) Medical Staff recognition.

(iii) In addition, the MPCC is responsible for:
(1) Reviewing recommendations from LMACs regarding requests for Privileges at local sites;
(2) Facilitating resolution of recruitment and privileging issues that cannot be resolved at the Department or Division level; and
(3) Providing advice on projects and initiatives undertaken by Medical and Academic Affairs related to the Medical Staff.

2.6.9.29 Voting Members

2.6.9.30 Voting members will be as follows:

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

2.6.9.31 Non-Voting Members

(i) An operational Executive Director
(ii) Director Medical Staff Support
(iii) Manager Credentialing & Privileging
(iv) Manager Medical Staff Recruitment & Retention
(v) Two (2) Members-at-Large

2.6.9.32 Frequency of Meetings

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

2.6.9.33 Legislative Committee (LC)

2.6.9.34 Purpose and Responsibilities

(i) 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.

(ii) 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.

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

(iv) Review the effects of legislation on the quality of medical care and/or the performance of Medical Staff as requested by HAMAC.

2.6.9.35 Voting Members

(i) Chair of the Legislative Committee

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

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

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

(v) At least one (1) representative from the MSA

2.6.9.36 Non-Voting Members

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

2.6.9.37 Frequency of Meetings

(i) The Legislative Committee will meet a minimum of two (2) times per year and more often at the call of the Chair to meet its purposes and responsibilities.

2.6.9.38 Medical Education Committee (MEC)

2.6.9.39 Purpose and Responsibilities

(i) 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.

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

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

(ii) 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;

(iii) Assisting Divisions, Departments and programs in the planning and coordination of educational activities;
(iv) Advising the HAMAC of rounds, clinical conferences, lectures and symposia being given by each Department;
(v) Assisting Divisions, Departments and programs in setting policies for continuing professional development; and
(vi) Providing representation on the VIHA Library Committee.

2.6.9.41 Voting Members

(i) MEC Chair;
(ii) A representative from each Department responsible for learners;
(iii) A representative from the Division of Public Health and Preventative Medicine;
(iv) The Medical Director of Aboriginal Health (or delegate); and
(v) A representative appointed by the HAMSA.

2.6.9.42 Non-Voting Members

(i) Three learner representatives;
(i) A representative from rural and remote sites;
(ii) The Regional Associate Dean for the Island Medical Program;
(iii) Consultants and advisors as the Committee deems appropriate; and
(iv) Up to four (4) members at large

2.6.9.43 Frequency of Meetings

(i) The MEC will meet 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.

2.6.9.44 Health Authority Medical Quality Committee (HAMQC)

(i) 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.
(ii) The HAMQC is responsible for the making recommendations to the HAMAC on:
(1) Medical Staff Quality Assurance (QA) data and measures;
(2) Medical Staff Quality Improvement (QI) initiatives;
(3) Development and implementation of VIHA QA/QI programs; and

(4) Medical Staff related issues identified by HAMAC that impact the quality of patient care.

2.6.9.45 Voting Members:

(i) The Chair of the HAMQC
(ii) Three (3) Department Heads or delegate
(iii) Four (4) Chiefs of Staff/Site Medical Director or delegate (one from each geography)
(iv) Medical Director, Residential Care, or delegate
(v) Four (4) representatives from the MSA (one from each geography)
(vi) The Medical Director for Aboriginal Health in VIHA or delegate.

2.6.9.46 Non-Voting Members

(i) Vice President Medicine, Quality and Academic Affairs;
(ii) A representative from the Combined Quality Oversight Council (CQOC);
(iii) A representative from the Quality Operations Council (QOC);
(iv) The Chief Medical Information Officer or delegate;
(v) An Island Health Medical Staff learner;
(vi) An approved patient representative; and
(vii) Up to four (4) members at large

2.6.9.47 Frequency of meetings

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

2.6.9.48 Ad Hoc Committees

2.3.9.40.1 Department Head Search Committee (DHSC)

The committee membership will be specific for each search or review process. Individual membership for each Search Committee will be established by medical administration in consultation with the clinical department and be approved by HAMAC. Membership will consist of:

(i) Chair of HAMAC or delegate;
(ii) One elected officer of the Medical Staff Association who is a HAMAC member;
(iii) Three members of the Medical Department for which a Head is being sought selected by the Department;
(iv) Senior Medical Administrator or delegate;
(v) Executive Medical Director to whom the Department Head reports;

(vi) Senior non-medical administrator relevant to the department for which a Head is being sought or reviewed; and

(vii) Other professional staff as appropriate to the position.

2.7 Teaching, Education and Research

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

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), the College of Midwives of BC (CMBC) and the BC College of Nursing Professionals (BCCNP).

2.7.1 Undergraduate Learners

2.7.1.1 Undergraduate learners include Medical Students and midwifery students.

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

2.7.2 Medical and Nurse Practitioner Students

2.7.2.1 Must have an educational license from the College of Physicians and Surgeons of BC (CPSBC) or registration with the BC College of Nursing Professionals (BCCNP)in order to train in VIHA Facilities and Programs.

2.7.2.2 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.

2.7.2.3 May perform Procedures under supervision of a Practitioner after adequate training and in compliance with the regulations of their educational institution.

2.7.2.4 Must advise patients of their trainee status.

2.7.2.5 Must ensure that orders are discussed in advance with the supervising Practitioner, Fellow or resident. It is the responsibility of the supervising Practitioner, Fellow or Resident to countersign the orders.

2.7.2.6 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.

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

2.7.2.8 May not sign prescriptions.

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

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

2.7.3 Midwifery students (UBC: Midwifery Policies and Procedures)

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

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

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

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

2.7.3.5 Are expected to be on call.

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

2.7.4 Postgraduate Learners (CPSBC: Postgraduate)

2.7.4.1 Residents must have an educational license from the College of Physicians and Surgeons of BC in order to train in VIHA Facilities and Programs. Fellows and Clinical Trainees must have either an educational license or other valid license to practice from the College of Physicians and Surgeons of BC in order to train in VIHA Facilities and Programs.

2.7.5 Residents (UBC Resident Policies and Procedures)

2.7.5.1 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.

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

2.7.5.3 Must advise patients of their trainee status.

2.7.5.4 Will 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.

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

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

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

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

2.7.5.9 Are expected to be on call.

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

2.7.6 Fellows

2.7.6.1 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.

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

(i) They are approved by the appropriate Department or Division Head; and
(ii) They are recommended by the HAMAC and approved by the Board of Directors.

2.7.6.3 Once approved, Fellows:

(i) May attend patients under the supervision of a member of the Medical Staff of the Department responsible for their supervision;
(ii) May carry out such duties as are assigned to them by the Department Head or delegate to whom they have been assigned;
(iii) May not admit patients under their name; and
(iv) May not vote at Medical Staff or Department meetings.

2.7.7 Medical Staff Preceptors and Supervisors:

2.7.7.1 The UBC affiliation agreement stipulates that the Faculty of Medicine will provide suitable appointments to the University for those Medical-Staff members who are involved in teaching programs of the University, subject to the University's policies and procedures.

2.7.7.2 To be involved in the teaching of UBC Medical Students and Residents, Practitioners will apply for and maintain an appointment with the UBC Faculty of Medicine.

2.7.7.3 All Medical-Staff members are expected to participate in teaching as a condition of

their appointment.

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

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

2.7.7.6 Medical-Staff members must advise patients or their designates when residents or students may be involved in their care and obtain consent for such participation.

2.7.7.7 Supervisors and preceptors must be available by phone or pager, when not available in person, to respond in a timely manner and be available to attend to the patient in an emergency. When not immediately available, they must ensure that an appropriate alternate Medical-Staff member is available and has agreed to provide supervision.

2.7.7.8 Supervisors and preceptors will assess, review and document Trainee competence in accordance with UBC policies.

2.7.7.9 Supervisors and Preceptors will comply with relevant policies of the affiliated Universities as well as Island Health when involved with students and trainees.

2.7.8 Research

2.7.8.1 VIHA views research as a core component of its mandate and encourages Medical Staff to contribute to the generation and application of evidence that will improve the quality of care provided. The requirements and resources available for conducting research in VIHA are as follows:

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

(ii) Research conducted at VIHA requires VIHA Research Ethics approval. This includes research involving subjects or their personal health information who are patients of the researcher.

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

(iv) Individuals conducting clinical research at VIHA, including interventions involving human research participants, must be trained in Good Clinical Practice (GCP) as defined by the International Council on Harmonization (ICH).

3 Medical Care in Long-term Care Facilities Operating under the Hospital Act

VIHA operates a number of long-term care facilities under Part 2 of the *Hospital Act*. The VIHA Medical Staff Rules apply to Practitioners providing care in VIHA-operated care facilities. This section highlights unique rules that guide the medical care of residents in Long-term Care facilities.

3.2 Most Responsible Practitioner (MRP)

3.2.1.1 The medical care of every resident will be directed and authorized by an appropriately-privileged Practitioner who will hold primary responsibility for the care of the resident. This Practitioner will be identified as the Most Responsible Practitioner (MRP).

3.2.1.2 MRPs are identified as Practitioners who agree to accept residents within a long-term care Facility under their medical direction. The MRP will be determined either prior to, or at the time of, admission.

3.2.1.3 The MRP is a collaborative care role in delivery of health and treatment services to residents. The MRP is the Practitioner responsible for directing and coordinating the medical care of a resident. In urgent situations where the MRP is not immediately available other duly-qualified Practitioners may provide immediate care.The MRP will be informed subsequently of such care.

3.2.1.4 The role of the MRP includes:

(i) Accepting residents from acute care sites, other Facilities, the community or from another practitioner;
(ii) Reviewing documentation and augmenting it as required to ensure that a full medical assessment is completed, including admission and continuing-care orders;
(iii) Working collaboratively with pharmacists and nurses to order appropriate medications, complete a Best Possible Medication History (BPMH) and perform the medication reconciliation. Discharge orders from acute-care Facilities will be considered valid for up to seven (7) days, pending confirmation by the MRP;
(iv) Providing periodic care, completing progress notes and overseeing the resident's medical care, either directly or through an on-call group;
(v) Communicating directly or through another staff member with the resident, their next of kin and legally-appointed Representative regarding medical conditions, any tests or consultations planned, and the results of such tests or consultations;
(vi) Working collaboratively with healthcare team members;
(vii) When necessary, resolving apparent treatment or medical care conflicts among shared-care providers;

(viii) Attending residents readmitted from acute care to assess the resident, conduct a review of documents and confirm admission orders within seven (7) days of admission or re-admission;
(ix) Proactively visiting each resident and documenting their status at least once every ninety (90) days;
(x) Attending annual multi-disciplinary care conference reviews;
(xi) Conducting meaningful medication reviews in consultation with pharmacy and nursing staff, at least once every six (6) months;
(xii) Notifying the Coroner of the circumstances in the case of an unnatural death including those resulting from a recent or remote accident;
(xiii) Participating in Advance Care Planning in collaboration with the resident or designate along with the health care team, no later than the time of the admission care-conference review. It should be updated as clinically indicated and at the annual care conference review.
(xiv) Facilitating and coordinating any discharge to the community, including communication with the primary-care Practitioner in the community, where present, as well as with community home-support; and
(xv) Prior to discharge, ensuring medication reconciliation and appropriate prescriptions are provided.

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

(i) Treatment changes, following a multidisciplinary care conference review, where the MRP has been invited and not been able to attend and where there is a team consensus that the change is in the best interest of the resident. In such cases the resident or their substitute decision maker must have been included in reaching consensus;
(ii) Referral for a psychiatric consultation where nursing staff and the Medical Coordinator deem it necessary for the ongoing care of the resident or the safety and protection of other residents or staff;
(iii) Medical orders to comply with infection-prevention and control requirements or recommendations of the Medical Health Officer;
(iv) Routine medical orders where the MRP has failed to respond to requests for care in a timely manner; and
(v) 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 3.2.1.5, the MRP will be informed as soon as possible.

3.2.2 Consultations, Shared Care and Transfer of Care

3.2.2.1 A consultation is a request for a professional opinion in the management of a resident.

Consultations may be on-site or off-site.

3.2.2.2 A consultation request will be made directly by 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 at the direction of the MRP.

3.2.2.3 An on-site consultation must include an in-person evaluation of the resident, a review of all necessary documentation and the provision of a timely, dictated or legible written or electronically entered report in keeping with VIHA standards. It will include both opinions and recommendations for management and treatment, as well as the basis for that advice. The consultant will notify the requesting Practitioner on completion of the consultation, either through direct communication or through the care team.

3.2.2.4 In the case of an off-site consultation at the consultant's office, documentation and communication will comply with the guidelines set forth by the College of Physicians and Surgeons of BC.

3.2.2.5 When available the MRP may make arrangements for co-management. This may take the form of co-managing with a medical staff member who is under contract to provide this service. If so, the terms of the co-management will be governed by facility policy. On-going and regular communication between the MRP and co-manager is required. Final decision making resides with the MRP.

3.2.2.6 A transfer-of-care request is a Practitioner-to-Practitioner request to transfer MRP status or other specific shared-care responsibilities to another Practitioner. Practitioners making such a request will supply a summary report detailing the medical care plan for the resident at the time of transfer. The transfer of MRP status (other than "on-call") from one Practitioner to another will be recorded on the Health Record. Transfer-of-care does not occur until the accepting Practitioner provides an order accepting transfer of care in the resident's record.

3.2.2.7 In those instances where a resident is transferred to another Facility or Program the MRP, if not resuming care at the new location, will ensure the transfer is completed in accordance with VIHA policy and will contact the receiving Practitioner to provide information regarding the plan of care and complete a discharge summary.

3.2.3 Reports

3.2.3.1 All consultations, referrals-of-care and transfer reports will follow best-practice guidelines of the Royal College of Physicians and Surgeons of Canada (RCPSC) and the College of Family Physicians of Canada (CFPC), and must meet the requirment identified in the EHR documentation standards. These reports are subject to practice audit to ensure compliance.

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

3.2.4 Discharge of Residents

3.2.4.1 The MRP or delegate will provide a discharge order and complete the discharge summary in compliance with the EHR documentation policy, including communication about the course in the Facility or Program, medications, follow-up plans, resident disposition and any advance care plans to the community Practitioners and healthcare professionals.

3.2.4.2 A discharge summary is required for all resident discharges. It is not required in the case of resident death.

3.2.4.3 To ensure continuity of care and resident 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 VIHA will ensure the transmission of copies to appropriate recipients within two (2) days following completion.

4 Regulated Provision of Care

4.2 Organ Donation and Retrieval

VIHA and its Medical Staff will cooperate with the British Columbia Transplant Society in supporting the provincial program for organ donation and retrieval.

4.2.1 Membership and Appointment

4.2.1.1 In cases where, under special or urgent circumstances, such as organ retrieval, temporary Medical Staff Privileges are required, the CEO may, in consultation with the Senior Medical Administrator, grant such appointments with specific conditions and for a designated purpose and period of time. These appointments must be ratified or terminated by the Board of Directors at its next meeting.

4.2.2 Responsibility for Patient Care

4.2.2.1 In the event of organ donation, responsibility for the maintenance of the physiological status of the organ donor may be transferred, at the discretion of the Most Responsible Practitioner, to a physician member of the Organ Retrieval Team.

4.2.2.2 Consent for organ and tissue donation will be validated through the British Columbia Transplant Society Registry or obtained through the patient's next of kin in accordance with the Human Tissue Gift Act and Regulations.

4.2.2.3 Organ donation, after the declaration of neurological or cardiac death, permits the

Most Responsible Practitioner to transfer to or share responsibility with the Organ Retrieval Team. Standard protocols available from the Organ Retrieval Team may be followed and orders may be given to a registered nurse or a respiratory therapist for the maintenance of the physiological status of the donor.

4.3 Delegation of a Medical Act

4.3.1 The delegation of a medical act to a registered member of another health profession defined under the Health Professions Act may be appropriate in certain restricted circumstances. Such delegation does not absolve the Medical Staff member of responsibility for the care of the patient but rather widens the circle of responsibility for the safe performance of the procedure. Responsibility is shared between the delegating Practitioner and the person who performs the delegated act.

4.3.2 The delegated medical act must be clearly defined and circumscribed by the degree of medical supervision required. The person to perform the act must agree to the delegation. Competency requirements of individuals and the scope of practice of a professional group must be determined to decide what additional training is needed. A Practitioner with relevant expertise must ensure the required knowledge and skill are taught appropriately. A non- Medical-Staff Practitioner may carry out the teaching, but not the examination for competence. Re-evaluation and, if necessary, re-training of all professionals who perform delegated medical acts should be conducted on a regular basis as required to maintain professional competency and an acceptable standard of care.

4.3.3 The Board of Directors, on the advice of the HAMAC, must approve all delegated medical acts before they can be performed within VIHA Facilities and Programs.

4.4 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.

4.4.1 Booking Requirements

4.4.1.1 Booking requests will be requested on behalf of the patient by the Practitioner or delegate who has the authority to perform or request the Procedure(s).

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

4.4.1.3 Required documentation, in accordance with established VIHA standards, will be submitted at the time of the booking request and Island Health will ensure that the documentation is uploaded in the EHR in a timely manner.

4.4.1.4 If scheduled treatments or Procedures are cancelled for administrative reasons, VIHA staff will be responsible for rebooking the Procedure(s) in consultation with the Practitioner and for notification of both the patient and the Practitioner, including the reason(s) for the cancellation.

4.4.2 Consent Requirements

4.4.2.1 VIHA consent policies and Procedures as well as applicable legislation will be followed at all times when obtaining and documenting consent for all electively scheduled procedures.

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

4.4.3 Requirements for Surgical Procedures

4.4.3.1 A surgeon will be the Most Responsible Practitioner for peri-operative management of the patient and for the performance of any surgical procedure. Post-operative MRP status will be determined in consultation with the accepting service.

4.4.3.2 When surgery performed by a Dentist will result in hospital admission, the Dentist is responsible to arrange admission by a Medical-Staff member with admitting Privileges. For outpatient or day surgery, the Dentist may provide a written or electronic history and physical exam from a medical Practitioner. The Dentist will act as MRP in these situations.

4.4.3.3 Surgery will be performed with the assistance of a second Medical-Staff member where VIHA policy so requires.

4.4.3.4 The manager or supervisor of the operating room may cancel any procedure(s) if there are insufficient resources or staff to proceed. The operation will be rescheduled in consultation with the MRP based on the primary considerations of the patient's well-being and the optimum management of the operating room facilities.

4.4.3.5 Prior to the commencement of any emergency surgery or procedure in the operating room, a Medical Staff member must ensure written or electronic documentation is available, including a brief history and physical exam, the patient's clinical status, and indication for the procedure to be performed.

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

4.4.3.7 The anesthesiologist or delegate will document any unusual circumstances related to the anesthetic or post-anesthetic recovery and specify those Practitioners who require copies of the documentation.

4.4.3.8 Before leaving the operating room, the surgeon will ensure that the required pathology

requisitions have been completed by the OR staff.

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

4.4.3.10 In compliance with the Coroners Act, any patient deaths that occur in the operating room or post anesthetic recovery area must be reported to the Coroner at the time of death. All such cases will be referred to the Surgical Quality Council for review.

4.4.4 Requirements for Non-Surgical Treatments and Procedures

4.4.4.1 On completion of a non-surgical treatment or procedure the Practitioner will document a progress note on the patient record, describing the treatment or procedure , and the outcome. This note will include any unusual circumstances or incidents of clinical significance related to the treatment or procedure. This note must identify those Practitioners who require copies of the report.

4.5 Pronouncement of Death, Autopsy and Pathology

4.5.1 VIHA policy governs those personnel who may pronounce an expected death. Only a member of the Medical Staff may pronounce a neurological or unexpected death. Only a Physician or Nurse Practitioner member of the Medical Staff may provide certification of death or stillbirth.

4.5.2 No autopsy will be performed without a Coroner's order or the written consent of the appropriate relative or legally authorized agent of the patient.

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

4.5.4 All tissue or material of diagnostic value will be sent to the Department of Pathology.

4.5.5 Pathology specimens including body tissues, organs, material and foreign bodies will not be released without due authorization by the Head of the Department of Laboratory Services or delegate.

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

4.6 Reporting & Managing Unprofessional Behaviour and Questions of Clinical Competence

General Principles:

1. The purpose of managing unprofessional behaviour is to create an environment that allows for both safe patient care and a respectful workplace.
2. Examples of unprofessional behavior include:
   (i) Behaviour that is contrary to the Code of Ethics of a Practitioner's Regulatory Body.
   (ii) Behaviour that is contrary to the Respectful Workplace Policy or the Principles of Partnership Governing Professionalism.
3. Standards of professional behaviour apply to both clinical and administrative work.
4. VIHA is committed to a policy of prevention and remediation, with a focus on early intervention to prevent problems escalating to a level where disciplinary action is required.
5. VIHA is committed to ensuring a fair and transparent process by ensuring concerns are investigated in a timely fashion for validity before proceeding to the remediation or disciplinary stage. The exception is a crisis intervention where immediate action is felt to be required to protect patient care or patient and staff security.
6. Protections for the person being investigated are embedded, including the ability to have a representative present and an appeal process.

4.6.1 Principles

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

4.6.1.2 All reports of unprofessional behaviour with an identified complainant, received verbally or in writing, will be considered carefully and addresssed. All verbal reports will be transcribed.

4.6.1.3 Where perceived unprofessional behaviour is observed or experienced in a VIHA Facility or Program, it should be reported to a Division Head, Department Head, or Site Chief of Staff. The medical leader who first receives such a report is responsible to ensure it is investigated and followed up in a timely manner.

4.6.1.4 Where perceived unprofessional behaviour involves a medical leader, it should be reported directly to the CMO or designate. If a perceived lack of psychological or physical safety exists, Medical Staff may report through the process outlined in the VIHA Safe Reporting Policy. The Safe Reporting Policy provides that a review of the conduct of any person associated with VIHA, including a member of the Medical Staff, may be initiated through the VIHA Safe Reporting Officer or General Counsel. The Safe Reporting Policy does not replace established procedures for managing unprofessional conduct as set out herein.

4.6.1.5 Reports of unprofessional behaviour will be investigated initially as soon as possible, usually within two (2) to four (4) weeks**.**

4.6.1.6 Retaliation against a reporter of unprofessional behaviour is expressly forbidden and

will result in disciplinary action against the perpetrator.

4.6.1.7 The review of a serious allegation involving a member of the Medical Staff will 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 will be referred to the HAMAC, who will make recommendations to the Board 4and CEO in accordance with Article 12 of the Bylaws.

4.6.1.8 Island Health will view seriously any report which proves to be false, malicious or of a frivolous nature, and that any person making such a report may be subject to discipline.

4.6.2 Managing Unprofessional Behaviour

4.6.2.1 Unprofessional behaviour is not tolerated in Island Health. Management of this behaviour requires a transparent investigative, evaluative and reporting system, known to the Practitioner from the outset and supporting a culture of just application of consequence. Detailed processes to support the fair and timely management of unprofessional behaviour are identified in Article 4.8 of these Rules.

4.6.3 Managing Issues of Clinical Competence

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

4.6.3.2 Concerns arising from clinical practice that 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 is described in Article 4.8 of these Rules.

4.6.4 Safe Reporting Policy

4.6.4.1 Island Health expects all Practitioners to report suspected wrongdoing through appropriate administrative channels. Alternately, individuals may report suspected wrongdoing to the Designated Central Point of Contact (DCPC) as defined within the VIHA Safe Reporting Policy, or the independent-third-party reporting service.

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

4.7 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 practitioner whose behaviour is felt to be inappropriate is a medical leader, the issue will be escalated to the medical leader to whom that practitioner reports. Wherever possible, minor incidents involving behaviour should be dealt with by respectful discussions between Medical Staff members. If the issue is resolved and there is no recurrence, further action is not required. Documentation may be done at the discretion of either party involved, but will not be filed with EMSS unless the issue is escalated to a Stage 1 intervention. When appearing at a meeting pertaining to unprofessional behaviour or standard of care issues, the Medical Staff member is entitled to bring another member of the Medical Staff or another representative to the meeting. The Chief of Staff will be advised of any Stage 1, 2 or 3 intervention. Escalation of interventions to level 1, 2, or 3 will be undertaken only after discussion with local Medical Leadership, Chief of Staff and EMSS. If there is disagreement with the level of intervention, HAMAC or LMAC may be asked to review.

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

4.7.1.1 Stage 1: This stage is warranted for behaviour that meet criteria for unprofessional conduct that could not be resolved informally or where unprofessional behaviour appears to be part of a recurring pattern. The Division Head, Department Head, or Chief of Staff will organize a formal meeting(s) with the Medical Staff Member. At their discretion they may involve and consult with Medical Leads, Medical Directors, or Executive Medical Directors..

4.7.1.2 Stage 2: This stage of intervention is warranted where a Stage 1 intervention has been ineffective. The Division Head, Department Head, or Chief of Staff will organize a formal meeting(s) with the Medical Staff Member. At their discretion they may involve and consult with Medical Leads, Medical Directors, or Executive Medical Directors. The process for management of Stage 2 discipline is outlined in article 4.6.2 of these Rules. The medical leader will notify the member that another incident may result in a Stage 3 intervention. The medical leader will provide a copy of the documentation to the Medical Staff member and forward a copy to EMSS for retention in the confidential Medical Staff database. A template for documentation will be provided by EMSS to the medical leader. Where Medical Staff members do not agree with the findings or remedial plan they may appeal to a more senior medical leader for review.

4.7.1.3 Stage 3: This stage of intervention is reserved for unprofessional behaviour that persists despite a Stage 2 intervention. This will automatically result in referal to HAMAC to determine further action. The process for management of Stage 3 discipline is outlined in article 4.6.2 of these Rules

4.7.1.4 Crisis Intervention:This stage of intervention is reserved for behaviour where immediate action is required to prevent harm or potential harm to patients, staff, Medical Staff, or the public. The process for management crisis intervention is outlined in article 4.6.2 of the Rules.

4.7.2 Uniform Approach for Managing Unprofessional Behaviour

4.7.2.1 Documentation of Stage 1, 2, 3 and Crisis Interventions will remain in the Medical Staff member's file permanently. This documentation will be securely maintained by the EMSS office. The MedicalStaff member has the right to review this file.

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

4.7.3 Managing Unprofessional Behaviour: Stage 1 Intervention.

4.7.3.1 The Division Head, Department Head or Chief of Staff/Site-Medical Director, in order to determine whether the complaint has validity and intervention is warranted, will:

(i) Meet with the Medical Staff member involved to describe the alleged incident.
(ii) Provide the Medical Staff member with an opportunity to describe events from their perspective;
(iii) Describe to the Medical Staff member how others have interpreted or received the behaviour;
(iv) Offer advice, guidance, and how to access resources for support, as appropriate;
(v) In discussion with the Medical Staff member, decide the format and substance of a resolution to the complaint, including a response to the complainant; and
(vi) Prepare the summary documentation of steps I to V.

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

4.7.4 Managing Unprofessional Behaviour: Stage 2 Intervention:

4.7.4.1 The Division Head, Department Head and/or Chief of Staff/Site-Medical Director will follow the process set forth under Stage 1 Intervention. Further, the Division Head, Department Head and/or Chief of Staff/Site-Medical Director will then work with the Medical Staff member to develop a contract between the Medical Staff member and VIHA, which will include the following:

(i) Method of redress (may include but is not limited to education, coaching, counselling, practice supervision or supervision of practice in another program with regular reports to be received by the Department Head and EMSS, psychological or other medical testing, substance use therapy, leadership training, written project or tutorial sessions) including referral of the Medical Staff member to an external resource such as a Practitioner Health Program;
(ii) Method of monitoring for change/progress;
(iii) Description of behaviour benchmarks;

(iv) Time frame within which progress must be demonstrable; and
(v) Consequences for failure to meet the terms of the contract.

4.7.4.2 The Division Head, Department Head or Chief of Staff/Site-Medical Director will notify the Medical Staff member in writing that another substantuated incident will result in review by the HAMAC in accordance with the Bylaws and that impact on Medical Staff Privileges may be determined at that time.

4.7.5 Managing Unprofessional Behaviour: Stage 3 Intervention:

4.7.5.1 The Department Head together with the Chief of Staff or Medical-Staff-Governance EMD will involve the CMO and the HAMAC Chair as soon as the requirement for Stage 3 investigation is identified. The Office of the CMO is responsible for the decision to initiate and for oversight of Stage 3 investigations. The CMO and the HAMAC Chair will schedule a review of the complaint by the HAMAC.

4.7.5.2 The HAMAC will:

(i) Review the behavioural and/or clinical care history of the Medical Staff member; and
(ii) If appropriate, recommend other rehabilitation strategies or disciplinary action.

4.7.5.3 Disciplinary action that the HAMAC may recommend includes but is not limited to:

(i) Modification, suspension, revocation, or refusal to renew a Medical Staff member's Privileges and Appointments to practice within VIHA.
(ii) Setting conditions that HAMAC deems appropriate.

4.7.5.4 Action on these recommendations will follow the process outlined in Article 12 of the Bylaws.

4.7.6 Managing Unprofessional Behaviour: Crisis Intervention:

4.7.7 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 will request the CMO or his/her delegate to consider summary suspension of Privileges as per Article 12.2 of the Bylaws. The CEO is also authorized to suspend per the Bylaws. Where the CMO or CEO is not immediately available, any Medical Staff leader has the authority to suspend the Practitioner, and will notify the CMO or CEO verbally and in writing of the suspension as soon as circumstances permit.

4.7.7.1 A HAMAC hearing will be held within 14 days to review the appropriateness of the summary suspension

4.7.7.2 The Department Head will assign the clinical duties to the appropriate department members.

4.8 Concerns about Clinical competence or failure to meet the standard of care will follow the same process of staged interventions.