3.0.1P

MEDICAL STAFF RULES

FOR

Island Health

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DEFINITIONS:

Term	Definition
Administrator on-Call	The senior administrator who acts as the primary Vancouver Island Health Authority (Island Health) contact outside regular working hours and who can be reached through the Island Health main switchboard.
Appointment	The process by which a Physician, Dentist, Midwife or Nurse Practitioner becomes a member of the Medical Staff of the Island Health.
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 Island Health.
Bylaws	The Island Health Medical Staff Bylaws.
Chief Executive Officer (CEO)	The person engaged by the Island Health 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 Island Health.
Chief Medical Executive (CME)	The senior medical administrator appointed by the Chief Executive Officer (CEO), currently titled Vice President Medicine and Quality.
Chief Nursing and Allied Health Officer (CNAHO)	A registered nurse appointed by the CEO of Island Health 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 CME 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 CME 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 Island Health 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 British Columbia College of Oral Health Professionals (BCCOHP) and entitled to practice Dentistry in British Columbia.
Department Head	The Department Head is accountable for the overall administration, leadership, and clinical performance of a specific department within Island Health. Department Heads work in partnership with their respective co-lead(s), as appropriate. They are responsible for the quality of medical care provided to patients by members of the Department, medical staff governance, operational and strategic planning, and workforce planning within the Department. The Department Head reports to CME and is appointed by the Board.
Division	A component of a Department composed of members with a clearly defined sub-specialty interest.
Division Head	The Division Head is responsible for the overall administration, leadership, and clinical performance of a specific division within Island Health. Division Heads work in partnership with their respective co-lead(s), as appropriate. They are responsible for the quality of medical care provided to patients by members of the Division, medical staff governance, operational and strategic planning, and workforce planning within the Division. The Division Head reports to a Department Head, except in the case of Division Heads of the Standalone Divisions, who report to the CME or their delegate. Division Heads role is recruited in alignment with organizational policy.
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)	An Executive Medical Director is a senior medical leader accountable for clinical governance and strategic and operational leadership over a defined portfolio. This role is expected to work in collaboration with other senior leaders within the organization, as appropriate. This role implements organizational strategy, oversees quality assurance programs, coordinates clinical leadership, and manages the performance and effectiveness of assigned medical services. The Executive Medical Director reports to the CME and is recruited in alignment with organizational policy.

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 Island Health 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 Island Health 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 members 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. The Department to which a member of the medical staff is assigned according to his/her training, and where the member delivers the majority of care to patients. All members of the Medical Staff must belong to and fulfill the responsibilities of their 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 subcommittee 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 Island Health.
Medical Staff Association (MSA)	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 MSA.
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 Island Health.
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 British Columbia College of Nurses and Midwives (BCCNM) 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 an Island Health owned or operated Facility or Program.
Nurse Practitioner	A member of the Medical Staff duly licensed by the BCCNM and entitled to practice as a Nurse Practitioner in British Columbia.
Oral and Maxillofacial Surgeon	A Dentist who holds a specialty certificate from the BCCOHP authorizing practice in Oral and Maxillofacial Surgery.
Patient-Centered Care	Care that places the patient and family at the center 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 British Columbia (CPSBC) 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 Island Health.

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 Island Health 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 Island Health booking services
Program	An ongoing care-delivery system under the jurisdiction of Island Health for coordinating a specified type of patient care.
Quality Lead	The Quality Lead provides oversight for special skills or privileges a member may have. The Quality Lead supports the Department or Division Head with ensuring members have adequate credentials and currency for a specific set of specialized skills through the privileging process, ensuring appropriate professional development, and quality reviews, as required. The Quality Lead reports to the Department or Division Head and is a recruited in alignment with organizational policy.
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 Island Health.
Section	A component of a Division composed of members with clearly defined sub-specialty interests.
Section Head	The Section Head is responsible for the overall administration, leadership, and clinical performance of a specific section within Island Health. Section Heads work in partnership with their respective co-lead(s), as appropriate. They are responsible for the clinical, academic, quality and governance activities of a Section. The Section Head role is recruited in alignment with organizational policy.
Site Chief	The Site Chief is the medical leader responsible for a specific service at a site. The Site Chief works in partnership with their respective co-lead, as appropriate, to ensure the continuous provision of services at the site. They are responsible for credentialling and privileging, recruitment, local quality matters, and medical staff oversight and review. Site Chiefs are members of the LMAC and play a vital role as a liaison between medical staff, the local site leadership, and the organization at large. Site Chiefs report to the Chief of Staff and have an indirect reporting relationship with their respective Department and/or Division Head. The role is recruited in alignment with organizational policy.

Quality Lead	The Quality Lead provides oversight for special skills or privileges a member may have. The Quality Lead supports the Department or Division Head with ensuring members have adequate credentials and currency for a specific set of specialized skills through the privileging process, ensuring appropriate professional development, and quality reviews, as required. The Quality Lead reports to the Department or Division Head and is a recruited in alignment with organizational policy.
Standalone Division	Standalone Divisions are separate structures from Departments and are comprised of medical staff from more than one Department working in the same specialized field of practice.
Temporary Privileges	A permit to practice in the Facilities and Programs operated by Island Health 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 Island Health for further clinical training.
Unprofessional Behaviour	Behaviour that contravenes the code of professional conduct of a Practitioner's Regulatory College or professional association, or Island Health policy.

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 Island Health. This accountability extends to the Chief Executive Officer (CEO), who is the Board's representative, as outlined in Section 3(1) of the Hospital Act Regulation. The Board grants Privileges to appropriately qualified Medical Staff members and employs the CEO to conduct the day-to-day affairs to ensure effective operation of the Facilities and Programs operated by Island Health. 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 Island Health'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 Island Health and the Medical Staff, and address requirements laid out in the Hospital Act and its Regulation. The Rules also address the accountability Medical Staff members have for their day-to-day practice in the Facilities and Programs operated by Island Health. The Rules apply to all members of the Medical Staff whether they are independent Practitioners, contracted Practitioners, or employees.

The members of the Medical Staff are accountable for the quality of Medical Care they provide in the Facilities and Programs operated by Island Health. 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. DECLARATION OF COMMITMENT

1.1.1. Respectful Workplace Policy

1.1.1.1. Island Health 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.

1.1.1.2. Island Health 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 Island Health Respectful Workplace Policy.

1.1.2. Cultural Safety

1.1.2.1. Island Health and its Medical Staff are committed to advancing cultural humility and cultural safety within health services, and are dedicated to ensuring that

(i) A guiding principle of cultural humility is used to build mutual trust and respect with First Nations and Indigenous patients, clients, visitors, and staff.

(ii) Cultural safety is understood to be embraced and practiced within all levels of the health system; including governance and individual professional practice.

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 an Island Health owned or operated Facility or Program is the MRP. 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 (ED).

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. See 1.2.4.4 and 1.2.4.5 regarding transfers.

1.2.1.6. The MRP is responsible to:

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

(ii) Ensure the completion and documentation of 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) Round on patients either directly or through an on-call group as often as the patient's clinical status warrants. Given that clinical status changes regularly, patients should be assessed promptly at the request of other members of the care team. In general:

- Acute patients with unstable or evolving clinical patterns should be assessed at least daily;
- Stable acute patients, sub-acute patients, and patients undergoing in-patient rehabilitation should be assessed at least once per week; and
- Stable patients awaiting placement in a long-term care facility should be assessed at least once every three to four weeks.

(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.

1.2.1.7. Where a clinical service has significant and ongoing workload or capacity concerns that they feel impacts their ability to accept MRP status for patients or care for patients under their service, the clinical service shall follow the management process outlined in the Service Capacity Management Procedure.

1.2.1.8. If a Member of the Medical Staff declines to accept MRP status for a patient to whom they are the most suited to provide care, outside of the processes articulated in the Service Capacity Management Procedure, the EP or transferring Practitioner, as the case may be, will contact the site COS during regular hours or the EMD on-call. At the earliest opportunity, the COS or EMD on-call will determine next steps to resolve the matter. The COS or EMD on-call may assign the role of MRP to a Member of the Department they believe is most suited to caring for the patient, who will be deemed to have accepted the patient for the purpose of responsibilities under the Medical Staff Rules and Bylaws. The COS or EMD on-call will then follow the Service Capacity Management Procedure to review and address the medical staff member's concerns. The LMAC may change any MRP assignment made under this provision, if necessary.

1.2.2. MRP for Admissions from the 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 exists from the ED regarding the most appropriate Practitioner for the role of MRP based on the patient's primary diagnosis and acuity, and this disagreement cannot be resolved between parties, the EP will contact the site Chief of Staff (COS) during regular hours or the Executive Medical Director (EMD) on-call after-hours At the earliest opportunity the COS or EMD on-call will determine next steps to resolve the disagreement. The COS or EMD on-call may assign the role of MRP to a Member of the Department they believe is most suited to caring for the patient, who will be deemed to have accepted the patient for the purpose of responsibilities under the Medical Staff Rules and Bylaws. The COS or EMD on-call will inform the LMAC, for information purposes, of admission disagreements managed under this provision.

1.2.3. MRP 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 Island Health.

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. This excludes routine out-patient laboratory testing and medical imaging appointments.

1.2.3.3. In exceptional circumstances, the CME 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's 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 Electronic Health Record (EHR) is implemented in an Island Health 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 Island Health 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 Island Health 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 Island Health 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, which 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 COS 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 must be completed, including required documentation.

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 Island Health 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 the 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 the HAMAC and the Board have approved an abbreviated discharge documentation process.

1.2.8.5. For uncomplicated obstetrical admissions, the British Columbia 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 Island Health 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 the HAMAC. The report must be dictated, 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 the 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 an Island Health-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 Island Health 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 inpatients in a manner acceptable to their Department or Division and the CME.

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) 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 excused by the Board on advice from HAMAC and the applicable Department Head, all Department members are required to participate equitably in fulfilling the on-call responsibilities of the Department. See 1.3.1.1.

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, in collaboration with Site Chiefs, 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 Island Health 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 Site Chief(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 Island Health 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 the 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 CME 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 EHR are those documents compiled by the medical and professional staff of Island Health 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. Island Health 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 Island Health. The exception is Medical Orders for Scope of Treatment (MOST), in which Physicians or Nurse Practitioner community primary care providers may enter a MOST designation either electronically or on paper.

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 Island Health Medication Orders Management Policy. Orders will be legible, accurate, contain only approved abbreviations, and adhere to Island Health'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 Island Health 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 should be completed as soon as possible after each patient interaction, if not contemporaneously.

1.4.4.2. Progress notes should include:

(i) The date and time of assessment or intervention;
(ii) Relevant changes 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 Island Health 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 Island Health 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 1.4.5.2 above, the appropriate Site Chief, Division Head, Department Head, or COS 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 Information 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 Information 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 Island Health 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. Island Health has a legal obligation to protect health information. The information belongs to the patient but Island Health 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 Island Health's 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 copies of 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 Island Health 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) Provincial legislation governing privacy and access to Health Records; and
(ii) Island Health 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 use or disclosure is authorized 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. Island Health 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 and Academic Affairs (MAA) expeditiously 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 Island Health 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 Island Health. The Board may grant Privileges for more than one Facility or Program after considering the recommendation of the HAMAC.

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

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

(i) Assessed using specialty-specific British Columbia provincial Privileging dictionaries; and
(ii) Granted by the Board on the recommendation of the HAMAC after an affirmative review of the training and competence of the Practitioner, the

service needs of Island Health, and the available resources in a specific Facility or Program operated by Island Health.

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 Island Health, and the available resources in a specific Facility or Program operated by Island Health.

1.5.3.6. Each Practitioner will be assigned to a Department.

1.5.3.7. A provisional, active, or consulting Staff member may apply for Privileges in another Facility or Program operated by Island Health. Additional Privileges may be granted by the Board following review of a recommendation by the HAMAC.

1.5.3.8. The process for specialist recruitment to the Medical Staff is defined in Island Health's Specialist Physician Recruitment Policy. The Appointment of a specialist requires completion of an Island Health 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) Honorary 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 period of active locum coverage must be approved in advance. When the approved period of coverage concludes, locum tenens staff cannot exercise their Privileges. For each subsequent locum-tenens coverage period a provisional, active, or consulting staff member must submit a completed locum scheduling form to the Credentialing and Privileging Office confirming coverage dates, which then must be approved by the Division or Department Head prior to locum tenens staff exercising their Privileges.

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 and Maintenance of Locum Privileges

1.5.6.1. A provisional, active, or consulting staff member must advise the Credentialing and 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 Executive (CME), 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 Island Health Medical Staff Privileges will be provided an application package for new locum tenens Privileges. The completed application package must be approved by the Division or Department Head, following which it will be forwarded to the Medical Planning and Credentials Committee (MPCC) and the 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 and 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, MAA must facilitate timely Island Health-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. Island Health 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 and 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 where Temporary Medical Staff may need to be appointed quickly, the CME, 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 Island Health HAMAC, MPCC, and MAA 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 Island Health before a final application can be reviewed by HAMAC and approved by the Board, the CME may grant an interim Appointment to the Medical Staff. The MPCC, or its 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 CME 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 Island Health 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 Island Health for further training in a clinical discipline. They must have medical liability insurance acceptable to Island Health, be licensed by the College of Physicians and Surgeons of British Columbia (CPSBC) and be registered with the Faculty of Medicine at the University of British Columbia (UBC). Clinical Fellows 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.

1.5.11.2. 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 Island Health. They may carry out such duties as are assigned to them by the Department Head 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 Departmental 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 Island Health for further clinical training. They must have adequate liability insurance and be licensed by the CPSBC, the British Columbia College of Oral Health Professionals (BCCOHP), or the British Columbia College of Nurses and Midwives (BCCNM). 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. Leave of Absence

1.5.13.1. 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.

1.5.13.2. Requests for medical leave need to be supported by the relevant medical documentation.

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

registrationstatus has been changed to temporarily inactive by the applicable college, the CME must receive acceptable supporting documentation that the Practitioner is fit to resume Privileges to practice in Island Health. 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 CME's decision to reject a request through the HAMAC to the Board.

1.5.13.4. Island Health Medical Staff Definition of Leave of Absence Policy provides additional information and guidance on processes related to LOA.

1.5.14. Reappointment to the Medical Staff

1.5.14.1. The process for Reappointment is set out in Article 4.4 of the Bylaws.

1.5.14.2. Island Health Medical Staff Reappointment Cycle Policy provides additional information and guidance on processes related to Reappointment.

1.5.15. Maintenance of Current Practitioner Information

1.5.15.1. Practitioners will inform MAA 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, criminal charges, and immigration status.

1.5.15.2. Practitioners will keep MAA updated on any changes to their contact information, including home, office or practice location addresses, email addresses, and telephone number(s).

1.5.16. In-Depth Practitioner Reviews

1.5.16.1. 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.

1.5.16.2. 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.

1.5.16.3. 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 the Site Chief, Division Heads, and sources including a Health Record review, outcome measures, incident reports or complaints, multi-sourced feedback from team members, and interviews with appropriate senior staff.

1.5.16.4. The practice and performance review may be completed by:

- (i) A Department Head
- (ii) A Division Head
- (iii) The COS of the local Facility,
- (iv) The Site Chief, or
- (v) An external reviewer, approved by the HAMAC on the recommendation of the Department Head, EMD, or CME.

1.5.16.5. 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 CME and ultimately HAMAC as necessary.

1.5.16.6. The MPCC, as defined in Article 2.5.9.27, will support the process for performance-reviews and report any concerns regarding consistency, validity, and procedural fairness to HAMAC.

1.5.17. Mid-Term Changes to Privileges

1.5.17.1. 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.

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

2. Organization of the Medical Staff

2.1. MEDICAL AND ACADEMIC AFFAIRS (MAA)

2.1.1. MAA 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;
- (vii) Continuing Professional Development (CPD); and
- (viii) Medical Staff wellness and resilience.

2.2. ORGANISATION OF THE MEDICAL STAFF

2.2.1. Island Health 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.

2.2.2. 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.

2.2.3. 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.

2.2.4. Departments

2.2.4.1. The Medical Staff Departments in Island Health will be:

(i) Anesthesiology, Pain, and Perioperative Medicine
(ii) Emergency Medicine
(iii) Family Physicians
(iv) Imaging Medicine
(v) Medicine
(vi) Midwifery
(vii) Nurse Practitioners
(viii) Obstetrics and Gynecology
(ix) Laboratory Medicine, Pathology, and Medical Genetics
(x) Pediatrics
(xi) Psychiatry
(xii) Public Health and Preventative Medicine
(xiii) Surgery

2.2.4.2. Departments are Health Authority wide structures, defined by specific colleges and residency training programs.

2.2.4.3. The scope of academic and clinical activity of a Department is specific to each site.

2.2.4.4. Departments will not necessarily have members or Site Chiefs at every site, reflecting local requirements and resource availability.

2.2.4.5. 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.

2.2.5. Divisions

2.2.5.1. Departments may be further organized into Divisions.

2.2.5.2. Divisions are clinically-defined specialty groups within a Department, in which the medical staff members work within entirely or almost entirely.

2.2.5.3. Divisions are Island Health wide structures.

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

2.2.6. Standalone Divisions

2.2.6.1. Standalone Divisions are created when members of more than one Department come together in a specialized field of practice.

2.2.6.2. Five Divisions are Standalone Divisions with voting membership on the HAMAC:

(i) Critical Care
(ii) Trauma
(iii) Addictions Medicine
(iv) Multidisciplinary and Interventional Pain
(v) Palliative Care and End of Life
(vi) Members of the Standalone Division also belong to a Department assigned based on specific college and residency training program.

2.2.7. Sections

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

2.2.7.2. Sections are Island Health wide structures.

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

2.2.8. Meetings

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

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

2.2.8.3. 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.

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

2.2.8.5. Meetings may be in-person, by video, or teleconference.

2.2.8.6. Active members of Medical Staff are required to attend at least 60% of 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 or Department Head regarding how this requirement will be fulfilled in the future.

2.2.8.7. Departmental leadership meetings will follow the meeting governance and operations processes as outlined in Article 2.5.1 to 2.5.8 of these rules.

2.3. MEDICAL STAFF DEPARTMENTAL LEADERSHIP

2.3.1. 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.

2.3.1.1. Physician-leadership oversight roles encompass:

(i) Standards of care and documentation;
(ii) Recruitment;
(iii) Resource planning;
(iv) Privileging;
(v) Performance monitoring & improvement;
(vi) Education & research;
(vii) Professional competence & behaviour;
(viii) Individual provider quality; and
(ix) Medical Staff wellness.

2.3.2. Department Heads

2.3.2.1. 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. A Provisional member of the medical staff may be appointed as Department Head in an acting capacity for a period of up to one year.

2.3.2.2. The responsibilities of the Department Head are outlined in Article 8.2 of the Bylaws and are Island Health wide in scope.

2.3.2.3. In addition to those duties outlined in Article 8.2 of the Bylaws, the Department Head will carry out such duties as assigned by the CME, or their designate.

2.3.2.4. Selection:

(i) The Department Head will be selected on the basis of qualifications, training, leadership experience, and demonstrated clinical, teaching, and administrative ability.
(ii) The Department Head will identify an alternate Medical Leader to assume the responsibilities of the role in the Department Head's absence, subject to the approval of the CME or designate.
(iii) Where a Department Head vacancy exists, the CME and HAMAC will strike a search committee.
    (1) Members of the HAMAC and the applicable Department will be represented on the committee.
    (2) The search committee will act in an advisory role to the CME, the HAMAC,

and the Board.

(3) Following the search process, the Department Head will be appointed by the Board upon the recommendation of the CME and the HAMAC after considering the advice of the search committee.

(4) 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 CME or another member recommended by the CME, on an interim basis.

(iv) 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.

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

(vi) If a Department Head resigns or is removed, the Board will delegate the responsibilities of the Department Head to the CME or another member recommended by the CME and said member will assume the responsibilities of the Department Head until a successor has been appointed.

2.3.2.5. Notwithstanding the sections of these rules regarding the appointment and term of a Department Head, the Department Head of Public Health and Preventative Medicine will be the Chief Medical Health Officer.

2.3.2.6. Reporting:

(i) The Department Head reports to, and is accountable to, the CME, or designate.

2.3.2.7. The Board of Directors, on the recommendation of the CME 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 CME, and the HAMAC Chair.

2.3.3. Division Head

2.3.3.1. The Division Head will be an active staff member of the Division who provides governance and leadership to Division members as outlined in the Bylaws and Rules. A Provisional member of the medical staff may be recruited as Division Head in an acting capacity for a period of up to one year.

2.3.3.2. The Division Head generally fulfils the same responsibilities for the Division as the Department Head does for the Department. These responsibilities are Island Health wide in scope. The Division Heads responsibilities are fulfilled in collaboration with the Department Head to ensure the quality of clinical services by Medical Staff within the Division meets an acceptable standard.

2.3.3.3. Selection:

(i) The Division Head will be selected on the basis of qualifications, training, leadership, experience, and demonstrated clinical, teaching, and

administrative ability.

(ii) The Division Head is recruited in alignment with organizational policies and reports to the respective Department Head.

(iii) 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.

2.3.3.4. Reporting:

(i) The Division Head reports to their Department Head. Where a Division Head has significant operational responsibility, the Division Head may also report to an Executive Medical Director as directed by the CME.

2.3.4. Section Head

2.3.4.1. 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. A Provisional member of the medical staff may be recruited as Section Head in an acting capacity for a period of up to one year.

2.3.4.2. The Section Head generally fulfils the same responsibilities for the Section as the Department Head does for the Department. These responsibilities are Island Health wide in scope. The Section Heads responsibilities are fulfilled in collaboration with the Division Head to ensure the quality of clinical services by Medical Staff within the Division meets an acceptable standard.

2.3.4.3. Selection

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

(ii) The Section Head will be recruited in alignment with organizational policies.

(iii) 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.

2.3.4.4. Reporting

(i) Section Heads report to their Division Head.

2.4. MEDICAL STAFF ASSOCIATION (MSA)

2.4.1 Health Authority Medical Staff Association (HAMSA)

2.4.1.1. The HAMSA is an Island Health-wide entity operating in accordance with Article 10 of the Bylaws and consists of all members of the Medical Staff.

2.4.1.2. 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.

2.4.2. HAMSA Executive Committee (HEC)

2.4.2.1. This committee is responsible to the Medical Staff of Island Health.

2.4.2.2. The HEC 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.

2.4.2.3. The functions of HEC are:

(i) To represent the collective voice of the Medical Staff members;
(ii) To advise the HAMAC and Island Health 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.

2.4.2.4. The HEC will annually elect one member to sit on HAMAC as a voting member, in addition to the 4 LMSA representatives.

2.4.2.5. 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.

2.4.3. Local Medical Staff Association (LMSA)

2.4.3.1. The LMSAs consist of all privileged Medical Staff at a local site and will operate in support of the HAMSA.

2.4.3.2. 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.

2.4.3.3. The duties of the LMSAs are:

(i) The LMSA President or delegate sits as a voting member of the LMAC and Local Quality and Operations Council (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 MSA;

(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.

2.4.4. The officers of LMSA Executive will consist of:

(i) President;

(ii) Vice-President; and

(iii) Treasurer.

2.4.4.1. Officers will be elected on an annual basis and may serve for a maximum of six (6) consecutive years in a particular office.

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

2.4.4.3. To avoid any conflict of interest, and subject to the exception below, LMSA Officers will not simultaneously hold an Island Health leadership role. Exceptionally, Facilities with limited Physician resources can hold dual positions and steps will be taken to declare and mitigate conflicts of interest.

2.4.5. LMSA Meetings

2.4.5.1. 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.

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

2.4.5.3. 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.

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

2.4.5.5. 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.

2.4.5.6. 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.

2.4.5.7. Members present at the meeting will constitute quorum.

2.5. MEDICAL STAFF COMMITTEES

General Principles of Governance and Operation

2.5.1. 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.

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

2.5.3. 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.

2.5.4. 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.

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

2.5.6. Each HAMAC subcommittee chair will provide the names of all committee members to the HAMAC secretariat annually and when changes occur.

2.5.7. The office of the CME provides secretariat support to the HAMAC and its subcommittees as described in the Bylaws.

2.5.8. All Medical Staff Committees are subcommittees of the HAMAC and report regularly to the HAMAC on proceedings at meetings. HAMAC may also strike ad hoc subcommittees as it considers necessary.

2.5.9. Health Authority Medical Advisory Committee (HAMAC)

2.5.9.1. Purpose and Responsibilities

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

2.5.9.3. The HAMAC makes recommendations to the Board with respect to:

(i) Appointment and review of members of the Island Health Medical Staff, including the delineation of clinical and procedural Privileges;
(ii) The quality, effectiveness, and availability of Medical Care provided within Island Health Facilities and Programs;
(iii) The establishment and maintenance of professional standards in Facilities and Programs operated by Island Health 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 Island Health including, but not limited to, the availability and adequacy

of existing resources to provide appropriate patient care;

(v) 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.

2.5.9.4. The HAMAC receives information from its subcommittees, Medical Departments, and clinical Programs, and provides advice to the Board based on that information.

2.5.9.5. Appointments to HAMAC:

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

(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.

2.5.9.6. Voting Members:

(i) Chair of the HAMAC
(ii) Vice-Chair of the HAMAC
(iii) Vice President Medicine and Quality & CME
(iv) Each Island Health Department Head and Standalone Division Head or delegate
(v) Each LMAC Chair representing site(s) with Acute Care beds.
(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

2.5.9.7. Non-voting Members:

(i) President and CEO
(ii) All EMDs of Island Health
(iii) HAMAC standing subcommittee Chairs
(iv) Other members of the senior administrative or Medical Staff of Island Health as appropriate and as agreed between the HAMAC Chair and CME.
(v) Patient Partner(s)

2.5.9.8. Standing Guests/HAMAC Support:

(i) Any Chairs of LMACs representing sites with no acute beds
(ii) Director; Office of VP Medicine, Quality, Research and CMO
(iii) Director; Medical Staff Governance
(iv) Coordinator(s); Medical Staff Governance

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

2.5.9.10. The HAMAC Executive Committee will be appointed by the Chair of HAMAC in consultation with the CME and with input from the HAMAC. The HAMAC Executive

membership will be ratified at the HAMAC Annual Organizational Meeting.

2.5.9.11. 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 CME.

2.5.9.12. The Executive Committee will be comprised of:

- (i) Chair of the HAMAC
- (ii) Vice-Chair of the HAMAC
- (iii) VP Medicine and Quality & CME
- (iv) One (1) MSA representative who is a voting member of the HAMAC
- (v) Two (2) Department Heads
- (vi) Other members as appropriate and appointed by the HAMAC Chair in consultation from the CME and with input from the HAMAC

2.5.9.13. Regular Meetings

The HAMAC will meet a minimum of five (5) 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 HAMAC 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.

2.5.9.14. 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 CME 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.

2.5.9.15. 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 videoconference 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.

2.5.9.16. Role and Responsibilities of the HAMAC Chair

(i) Acts as the principle spokesperson for the HAMAC in liaising with the CEO, the CME, 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.

2.5.9.17. Local Medical Advisory Committees (LMAC)

(i) The LMAC is a site-specific subcommittee of the HAMAC that fulfills the same duties and functions as HAMAC at the local level. It is usually chaired by the COS 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 and s.46(6) of the Hospital 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 and s.46 (6) of the Hospital 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 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.

2.5.9.18. Voting Members:

(i) If not the Chair, the COS retains voting membership on the LMAC

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

(iii) All Site Chiefs. Site Chiefs not present at a site may delegate their responsibility to a local Member of the Medical Staff.

(iv) 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.

2.5.9.19. Non-Voting Members:

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

(ii) Geography EMD and Executive Director

2.5.9.20. Frequency of LMAC Meetings

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

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

(1) Cowichan District Hospital

(2) Lady Minto Gulf Islands Hospital

(3) Nanaimo Regional General Hospital

(4) North Island Hospitals (Campbell River Hospital and Comox Valley Hospital)

(4) Saanich Peninsula Hospital

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

(6) Tofino General Hospital

(7) West Coast General Hospital

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

2.5.9.21. Standing Subcommittees

2.5.9.22. 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 LMACs as outlined in Article 10.1 of the Bylaws.

2.5.9.23. 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.

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

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

2.5.9.26. Medical Planning and Credentials Committee (MPCC)

2.5.9.27. 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:
(1) Medical Staff recruitment;
(2) Credentialing, Privileging, Appointment, and Reappointment;
(3) Medical Staff performance review and;
(4) 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 MAA related to the Medical Staff.

2.5.9.28. Voting Members
(i) Chair
(ii) EMD; Clinical Operations
(iii) Medical Director; Medical Staff Credentialing, Privileging, & Governance
(iv) Medical Director; Medical Staff Human Resources & Recruitment
(v) Department Heads and Standalone Division Heads (or Delegate)
(vi) Four (4) Chiefs of Staff

2.5.9.29. Non-Voting Members
(i) Executive Director; Clinical Operations

(ii) EMD; Medical Staff Governance
(iii) Director; Medical Staff Support and Resources
(iv) Medical Director; EMSS
(v) Manager; Credentialing and Privileging
(vi) Manager; Medical Staff Human Resource Planning & Governance
(vii) Manager; Medical Staff Recruitment
(viii) Two Members-at-Large
(ix) One (1) Representative from each Recruitment and Credentialing & Privileging
(x) Patient Partner
(xi) One (1) HAMSA representative, as nominated by the HAMSA and/or MSA President
(xii) Other Chiefs of Staff

2.5.9.30. 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.

2.5.9.31. Legislative Committee (LC)

2.5.9.32. Purpose and Responsibilities

(i) The Legislative Committee (LC) makes recommendations to the HAMAC on the development, implementation, monitoring and revision of the Island Health Medical Staff Bylaws, Rules and Policies.
(ii) Changes to the Bylaws must be approved in writing by the CEO, Board Chairand 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.
(v) To embed the organizational culture within the Rules, including commitments to diversity, equity, inclusion, and cultural safety.

2.5.9.33. Voting Members

(i) Chair of the Legislative Committee
(ii) A minimum of five (5) voting members of the HAMAC
(iii) VP Medicine and Quality & CME (or delegate)
(iv) At least one (1) MSA representative from each Geo
(v) Indigenous Health Representative
(vi) Other members of the Medical and/or hospital staff as the Committee deems appropriate

2.5.9.34. Non-Voting Members

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

2.5.9.35. 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.

2.5.9.36. Medical Education Resource Committee (MERC)

2.5.9.37. Purpose

(i) The MERC supports the HAMAC by addressing policy and procedures related to Medical Staff CPD and serves as a connection for medical academic institutions.

2.5.9.38. Responsibilities

The MERC is a standing committee of HAMAC. The MERC serves in an advisory role to the HAMAC and is responsible for making recommendations and reporting to the HAMAC on:

(i) Identification and prioritization of learning needs, particularly regional specific learning opportunities for clinicians, including rural community needs, Indigenous Health and cultural learning.
(ii) Assist Departments, Divisions, and MSAs in the planning, promotion, and coordination of continuing educational activities and informal learning opportunities, including Department-level tracking and evaluation.
(iii) Support the translation of provider quality assurance challenges into educational opportunities through the endorsement of evidence based and best practice learning.
(iv) Endorse educational content on the Medical Staff website and Island Health Libraries, including the promotion of course offerings through the LearningHub.
(v) Support and promote access to interdisciplinary educational opportunities, and learning opportunities through provincial initiatives such as Medical Staff practice enhancement.
(vi) Liaising with UBC, other academic institutions, and the Centre of Interprofessional Clinical Simulation Learning to ensure coordinated and focused learning opportunities for Medical Staff.
(vii) Support of the Medical Staff onboarding process and implementation, including solicitation of feedback from Departments, Divisions, and MSAs to evaluate and update process and endorsement of educational content.
(viii) Support applications of learning through an equity diversity and inclusion lens.

2.5.9.39. Voting Members

(i) MERC chair
(ii) Department Heads (2)
(iii) MAA (2)
    (1) EMD; Medical Staff Governance
    (2) Manager; Medical Staff Education & Development
(iv) HAMQC (2)
    (1) Director; Medical Staff Quality & Clinical Improvement
    (2) Medical Director; Quality, Safety, & Ethics
(v) MPCC: Chair or delegate
(vi) Island Medical Program: Director, Physician Education
(vii) Members at Large, (2) – appointed by Department Heads.
(viii) Indigenous Health Representative
(ix) Rural CME Liaison

(x) Rural Medicine Physician Representative
(xi) Executive Director; Medication Systems & Medical Informatics
(xii) Patient Partner

2.5.9.40. Non-Voting Members
(i) Chair of HAMAC
(ii) Vice President; Medicine and Quality & CME
(iii) Regional Dean; UBC Island Medical Program
(iv) Head; UVic Division of Medical Sciences
(v) Director; Professional Practice
(vi) Orientation and Onboarding Coordinator
(vii) Director; Centre for Interprofessional Clinical Simulation Learning

2.5.9.41. Frequency of Meetings
(i) The MERC will meet a minimum of six (6) 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.

2.5.9.42. The Chair of the MERC is appointed for a term of two (2) years, which can be renewed upon expiry. Membership is role-based with no term end date.

2.5.9.43. Health Authority Medical Quality Committee (HAMQC)

2.5.9.44. Purpose and Responsibilities
(i) Reporting to the HAMAC, the HAMQC aligns with the Island Health 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 Island Health 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 Island Health QA/QI programs; and
  (4) Medical Staff related issues identified by HAMAC that potentially impact the quality of patient care.

2.5.9.45. Voting Members:
(i) Co-Chair – EMD; Quality, Safety & Improvement
(ii) Co-Chair – EMD; Medical Staff Governance
(iii) Medical Director; Clinical Improvement & Medical Staff Development
(iv) Up to four (4) Department Heads (or Delegates)
(v) Four (4) Chiefs of Staff or delegate (one from each geography)
(vi) Four (4) representatives from the MSA (one from each geography)
(vii) Medical Director, Long Term Care (or Delegate)
(viii) Medical Director, Indigenous Health (or Delegate)
(ix) Medical Director, Quality Operations Council (QOC)
(x) HAMAC Chair
(xi) Chief Medical Information Officer (CMIO) (or Delegate)
(xii) Director, Medical Quality, Analytics & Improvement

(xiii) Formal Patient Representative
(xiv) Up to four (4) Medical Staff Members at Large
(xv) Medication System and Therapeutics Quality Council/Pharmacy Representative
(xvi) Infection Management Advisory Committee Representative

2.5.9.46. Non-Voting Members

(i) Executive Director; Quality, Safety & Improvement
(ii) Two (2) Data Analytics/Decision Support
(iii) Medical Staff Governance Representative
(iv) Medical Staff Governance Coordinator
(v) Consultants and advisors as deemed appropriate by the HAMAC

2.5.9.47. 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.

2.5.9.48. Chair of the HAMQC

(i) Chair appointment is aligned with the roles of EMD of Medical Staff Governance and EMD of Quality, Safety, & Improvement.
(ii) Should the Co-Chairs be unavailable, the responsibility of Chair will be delegated to the Director of Medial Staff Quality, Analytics, & Improvement and Medical Director of Clinical Improvement & Medical Staff Development.

2.5.9.49. Ad Hoc Committees

(i) 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:
(1) Chair of HAMAC or delegate;
(2) One elected officer of the MSA who is a HAMAC member;
(3) Three members of the Medical Department for which a Head is being sought selected by the Department;
(4) Senior Medical Administrator or delegate;
(5) EMD to whom the Department Head reports;
(6) Senior non-medical administrator relevant to the Department for which a Head is being sought or reviewed; and
(7) Other professional staff as appropriate to the position.

2.6. TEACHING, EDUCATION, AND RESEARCH

Island Health Medical Staff value the partnership with Post-Secondary institutions and are committed to providing quality practice education opportunities for students, Residents, Clinical Trainees, and Clinical Fellows. Medical Staff are expected to support learners either formally or informally by engaging in opportunities to teach, preceptor, and by always leading by example.

2.6.1. Residents and Students

2.6.1.1. Residents (UBC Resident Policies and Procedures)

- (i) Residents are not members of the Medical Staff as defined in the Bylaws.
- (ii) Residents must have an educational license from the CPSBC in order to train in Island Health Facilities and Programs.
- (iii) 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.
- (iv) May carry out such duties as assigned by the supervising Medical Staff member.
- (v) Must advise patients of their Trainee status.
- (vi) 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.
- (vii) May not sign birth or death certificates and may not request autopsies.
- (viii) May not admit patients to a Facility or Program except under the direction of a member of the Medical Staff.
- (ix) Residents must be supervised at all times when on call.

2.6.1.2. Students

- (i) Medical, Midwifery, Nurse Practitioner, and Dental Students are not members of the Medical Staff as defined in the Bylaws.
- (ii) 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 UBC, be attending a WHO/FAIMER-recognized medical school, or be attending a school with which Island Health has an affiliation agreement.
- (iii) Medical Students must have an educational license from the CPSBC in order to train in Island Health Facilities and Programs.
- (iv) In preparation for training at Island Health students are required to complete specific onboarding requirements as mandated by both UBC and Island Health.
- (v) Although not members of the Medical Staff, students must abide by the policies and guidelines of Island Health and its Medical Staff.
- (vi) 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.
- (vii) 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.
- (viii) Students may perform Procedures under supervision of a Practitioner after adequate training and in compliance with the Regulations of their educational institution.
- (ix) Students must advise patients of their Trainee status.
- (x) Students will not discharge patients without appropriate review by a qualified member of the Medical Staff
- (xi) Students may not sign birth and death certificates, mental health certificates or other medico-legal documents.

(xii) Students must be supervised at all times when on call.

2.6.1.3. Medical Staff Preceptors and Supervisors

(i) 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.

(ii) 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.

(iii) Medical Staff members are not responsible for onboarding or verifying that learners have met all the onboarding requirements as mandated by UBC or other affiliate universities and Island Health.

(iv) Medical Staff members 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.

(v) 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.

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

(vii) Supervisors and Preceptors will comply with relevant policies of the affiliated Universities as well as Island Health when involved with students and Trainees.

2.6.2. Research

2.6.2.1. Island Health 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 Island Health are as follows:

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

(ii) Research conducted at Island Health requires Island Health 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 Island Health Department(s) involved in the support or conduct of the research project.

(iv) Individuals conducting clinical research at Island Health, 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

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

3.1. MOST RESPONSIBLE PRACTITIONER (MRP)

3.1.1. 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 MRP.

3.1.1.1. 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.

3.1.1.2. 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.

3.1.1.3. 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 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

3.1.1.4. Prior to discharge, ensuring medication reconciliation and appropriate prescriptions are provided. 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 3.1.1.4, the MRP will be informed as soon as possible.

3.1.2. Consultations, Shared Care, and Transfer of Care

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

3.1.2.2. 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.

3.1.2.3. 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 Island Health 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.

3.1.2.4. 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 CPSBC.

3.1.2.5. 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.

3.1.2.6. 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.

3.1.2.7. 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 Island Health policy and will contact the receiving Practitioner to provide information regarding the plan of care and complete a discharge summary.

3.1.3. Reports

3.1.3.1. All consultations, referrals-of-care and transfer reports will follow best-practice guidelines of the RCPSC and the CFPC, and must meet the requirement identified in the EHR documentation standards. These reports are subject to practice audit to ensure compliance.

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

3.1.4. Discharge of Residents

3.1.4.1. 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.

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

3.1.4.3. 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 Island Health will ensure the transmission of copies to appropriate recipients within two (2) days following completion.

4. Regulated Provision of Care

4.1. ORGAN DONATION AND RETRIEVAL

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

4.1.1. Membership and Appointment

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

4.1.2. Responsibility for Patient Care

4.1.2.1. In the event of organ donation, responsibility for the maintenance of the physiological status of the organ donor may be transferred, at the discretion of the MRP, to a Physician member of the Organ Retrieval Team.

4.1.2.2. 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.

4.1.2.3. Organ donation, after the declaration of neurological or cardiac death, permits the MRP to transfer to or share responsibility with the Organ Retrieval Team. Standard protocols available from the Organ Retrieval Team may be followed and orders may be given to a registered nurse or a respiratory therapist for the maintenance of the physiological status of the donor.

4.2. DELEGATION OF A MEDICAL ACT

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

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

regular basis as required to maintain professional competency and an acceptable standard of care.

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

4.3. 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 Island Health booking services.

4.3.1. Booking Requirements

4.3.1.1. 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).

4.3.1.2. Booking requests will be submitted in accordance with approved Island Health booking request forms, processes, and timelines.

4.3.1.3. Required documentation, in accordance with established Island Health 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.

4.3.1.4. If scheduled treatments or Procedures are cancelled for administrative reasons, Island Health 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.

4.3.2. Consent Requirements

4.3.2.1. Island Health 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.

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

4.3.3. Requirements for Surgical Procedures

4.3.3.1. A surgeon will be the MRP for perioperative 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.

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

4.3.3.3. Surgery will be performed with the assistance of a second Medical Staff member where Island Health policy so requires.

4.3.3.4. The manager or supervisor of the operating room may cancel any Procedure(s) if there are insufficient resources or staff to proceed. The operation 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.

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

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

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

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

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

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

4.3.4. Requirements for Non-Surgical Treatments and Procedures

4.3.4.1. On completion of a non-surgical treatment or Procedure the Practitioner 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.

4.4. PRONOUNCEMENT OF DEATH, AUTOPSY AND PATHOLOGY

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

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

4.4.3. In appropriate cases, the MRP will make all reasonable efforts to obtain permission for the performance of an autopsy.

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

4.4.5. 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.

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

4.5. REPORTING & MANAGING UNPROFESSIONAL BEHAVIOUR AND QUESTIONS OF CLINICAL COMPETENCE OR FAILURE TO MEET APPROPRIATE STANDARD OF CARE

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. Island Health is committed to a policy of prevention and remediation, with a focus on early intervention, if feasible, to prevent problems escalating to a level where disciplinary action is required.
5. Island Health 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/or staff security.
6. Protections for the person being investigated are embedded, including the ability to have a representative present and an appeal process.

4.5.1. Principles

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

4.5.1.2. All reports of Unprofessional Behaviour with an identified complainant, received verbally or in writing, will be considered carefully and addressed. All verbal reports will be transcribed.

4.5.1.3. Where perceived Unprofessional Behaviour or concerns about clinical competence are observed or experienced in an Island Health Facility or Program, it should be reported to a Site Chief, Division Head, Department Head, or COS. The Medical Leader who first receives such a report is responsible to ensure it is investigated and followed up in a timely

manner.

4.5.1.4. Where perceived Unprofessional Behaviour involves a Medical Leader, it should be reported directly to the CME or designate. If a perceived lack of psychological or physical safety exists, Medical Staff may report through the process outlined in the Island Health Safe Reporting Policy. The Safe Reporting Policy provides that a review of the conduct of any person associated with Island Health, including a member of the Medical Staff, may be initiated through the Island Health Safe Reporting Officer or General Counsel. The Safe Reporting Policy does not replace established procedures for managing unprofessional conduct as set out herein.Reports of Unprofessional Behaviour will be investigated initially as soon as possible, usually within two (2) to four (4) weeks.

4.5.1.5. Retaliation against a reporter of Unprofessional Behaviour or clinical concerns is expressly forbidden and will result in disciplinary action against the perpetrator.

4.5.1.6. The review of a serious allegation involving a member of the Medical Staff will be conducted in consultation with the CME'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 and CEO in accordance with Article 12 of the Bylaws. Emergency suspensions are dealt with in accordance with Article 12.2 of the Bylaws.

4.5.1.7. 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.

4.5.2. Managing Unprofessional Behaviour

4.5.2.1. 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 4.7 of these Rules.

4.5.3. Managing Issues of Clinical Competence

4.5.3.1. 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.

4.5.3.2. 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 4.7 of these Rules.

4.5.4. Safe Reporting Policy

4.5.4.1. 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 Island Health Safe Reporting Policy, or the independent-third-party reporting service.

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

4.6. 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 or concerns and determine their 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 (and should be done in case of repeat behaviour) 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 COS 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, COS and EMSS unless immediate action is required (see 4.6.1.4). If there is disagreement with the level of intervention, HAMAC or LMAC may be asked to review.

4.6.1. Interventions have the goal of remediation and will generally follow a staged approach, as outlined below. These interventions must be documented.

4.6.1.1. Stage 1: This stage is warranted for behaviour that meets criteria for unprofessional conduct that could not be resolved informally, or where Unprofessional Behaviour appears to be part of a recurring pattern. The Site Chief, Division Head, Department Head, or COS will organize a formal meeting(s) with the Medical Staff Member. At their discretion they may involve and consult with other Medical Leaders, as appropriate.

4.6.1.2. Stage 2: This stage of intervention is warranted where a Stage 1 intervention has been ineffective. The Site Chief, Division Head, Department Head, or COS will organize a formal meeting(s) with the Medical Staff Member. At their discretion they may involve and consult with other medical leaders, as appropriate. 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.

4.6.1.3. Stage 3: This stage of intervention is reserved for Unprofessional Behaviour or for serious clinical concerns that persist despite a Stage 2 intervention. This will automatically result in referral to HAMAC to determine further action.

4.6.1.4. Crisis Intervention: This stage of intervention is reserved for behaviour or clinical concerns where immediate action is required to prevent harm or potential harm to patients, staff, Medical Staff, or the public.

4.6.2. Uniform Approach for Managing Unprofessional Behaviour and Concerns about Competence and Failure to Meet Appropriate Standards of Care

4.6.2.1. 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 Medical Staff member has the right to review this file.

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

4.6.3. Stage 1 Intervention

4.6.3.1. The Site Chief, Division Head, Department Head or COS, 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 and review any relevant documents or patient charts.
(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 or concern, 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.

4.6.4. Stage 2 Intervention

4.6.4.1. The Site Chief, Division Head, Department Head and/or COS will follow the process set forth under Stage 1 Intervention. The Site Chief, Division Head, Department Head and/or COS will then work with the Medical Staff member to develop a contract between the Medical Staff member and Island Health, 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.

In the case of clinical concerns an external review may be obtained and appropriate remediation will be considered if feasible.

4.6.4.2. The Site Chief, Division Head, Department Head, or COS will notify the Medical Staff member in writing that another substantiated 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.

4.6.5. Stage 3 Intervention

4.6.5.1. The Department Head, together with the COS or appropriate EMD, will involve the CME and the HAMAC Chair as soon as the requirement for Stage 3 investigation is identified. Legal advice should be considered. The Office of the CME is responsible for the decision to initiate and for oversight of Stage 3 investigations. An external review will be initiated if considered appropriate. The CME and the HAMAC Chair will schedule a review of the complaint by the HAMAC.

4.6.5.2. 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.

4.6.5.3. 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 Island Health.
(ii) Setting conditions that HAMAC deems appropriate.

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

4.6.6. Crisis Intervention

4.6.6.1. Where behaviour is too egregious or care deemed too unsafe to warrant staged intervention, the Site Chief, Division Head, Department Head, or COS will request the CME 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 CME or CEO is not immediately available, any Medical Staff leader has the authority to suspend the Practitioner, and will notify the CME or CEO verbally and in writing of the suspension as soon as circumstances permit.

4.6.6.2. A HAMAC hearing will be held within 14 days to review the appropriateness of the summary suspension unless otherwise agreed with the Practitioner and/or his or her counsel.

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