



Groves Memorial Community Hospital (GMCH) and North Wellington Health Care Corporation (NWHC)

Professional Staff Rules & Regulations

Original: GMCH Board Meeting February 11, 2014
NWHC Board Meeting February 13, 2014
Updated: October 2017
December 2021
March 2022

This document has had extensive consultations and is based on the Ontario Hospital Association's and Ontario Medical Association's best practices.

GROVES MEMORIAL COMMUNITY HOSPITAL
And
NORTH WELLINGTON HEALTH CARE CORPORATION

PROFESSIONAL STAFF RULES & REGULATIONS

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GENERAL INTRODUCTION

The Medical Advisory Committee (MAC) is required by Legislation to make recommendations to the Board regarding the establishment and/or amendment of general and departmental rules for the Professional Staff.

Rules are designed to expand on the Bylaw in areas where changes may occur from time to time, and must not contradict the Bylaw or Legislation governing the hospital.

Rules are meant to clarify the duties and responsibilities of the attending practitioner. The Bylaw and Rules constitute a contract between the practitioner and the Board of Directors allowing both to be accountable to the patients and to society for the quality of care.

All members of the Professional Staff are expected to be familiar with the rules and to act in accordance with them. Furthermore, all members are expected to stay current with directives from their regulatory authorities.

DEFINITIONS

- (a) Admissions
 - i) Elective
An admission of a patient for a condition that, in the judgment of the practitioner, may wait more than or equal to seventy-two (72) hours.
 - ii) Urgent
An admission of a patient who, in the judgment of the practitioner, requires admission within twenty four (24) hours.
 - iii) Emergent
An admission of a patient for a potentially life- or limb-threatening condition.
- (b) Admitting Practitioner
Is the person who requests or arranges the admission of a patient to hospital.
- (c) Clinical Rules
Rules that apply to clinical situations.
- (d) Consultation
For the purpose of these rules, a consultation shall mean attending the patient personally as set out in the legislated Schedule of Benefits.
- (e) Most Responsible Practitioner/Provider (MRP)
Is the practitioner who is responsible for the coordination of the care for the patient. Every patient must have an MRP at all times. MRP is determined by The Hospital MRP Policy. (**Note in Hospital Meditech Electronic Health Record the MRP is referred to as the Attending Physician)
- (f) Professional Staff
The professional staff is composed of all physicians, midwives, dentists and nurse practitioners (extended class nursing staff) who are credentialed at The Hospital.
- (g) Medical Staff
The medical staff is composed of all physicians whose credentialing permits them to act as MRP for a patient at The Hospital.

GENERAL RULES

ARTICLE I. PROFESSIONAL STAFF ASSOCIATION (PSA)

SECTION 1.01 PROFESSIONAL STAFF DUES (PHYSICIANS ONLY)

The general Professional Staff shall determine Professional Staff due amounts and collection processes. The Professional Staff shall determine the purposes for which the dues shall be used.

SECTION 1.02 TERMS OF OFFICE/ELECTION PROCESS

The PSA Officers (President, Vice-President and Secretary) shall be elected for a two-year term. The President may be re-elected up to twice and the Vice-President and Secretary may be re-elected once.

Only active members of Medical Staff may serve as PSA officers. Members can be nominated for more than one position however they must submit separate nomination forms for each position (Appendix 1 - Nomination Form). Nominations will also be accepted from the floor at the Annual General Meeting.

On-call Professional Staff may participate in the PSA election through proxy voting. Proxy forms will be sent to the Professional Staff on call prior to the meeting (Appendix 2 - Proxy Vote).

SECTION 1.03 PROFESSIONAL STAFF ASSOCIATION MEETINGS

The order of business at the annual meeting of the Professional Staff association shall include at least:

- Approve minutes of the previous meeting
- Business arising from the minutes
- Review report of the MAC which shall include recommendations for the improvement of the medical work within the hospital and which may include reports from any standing or special committees
- Review report of the elected officers of the Professional Staff
- Receive nominations for the Professional Staff elections, e.g. the report of the Nominating Committee
- Elect officers (for the following year)
- If necessary, elect a Nominating Committee (for the following year)
- Determine a time and place for the next annual meeting
- Determine a time and place for meetings of the Professional Staff before the next annual meeting
- Adjournment

The order of business at a regular Professional Staff meeting shall include at least:

- Approve minutes of the last regular meeting and of any special meeting since the last regular meeting

- Business arising from the minutes
- Receive reports from Professional Staff Association committees on non-clinical matters
- Receive report of the Board (President of the Professional Staff)
- Receive report of the Hospital Management (Chief of Staff)
- Receive report of the MAC which shall include recommendations for the improvement of the medical work within the Hospital and which may include reports from any special or standing committees
- New business
- Adjournment

The order of business at a special meeting of the Professional Staff shall include at least:

- Read the notice calling the meeting
- Where the usual period of time required for giving notice is waived, the waiving of notice shall be voted upon and business shall continue only if the action of waiving notice is ratified by a majority of members present and eligible to vote
- Take care of the business for which the meeting was called
- Adjournment

Quorum at Professional Staff meetings shall be 50% of the Medical Staff.

SECTION 1.04 SUPERVISORS OF ASSOCIATE STAFF MEMBERS

A supervisor shall be a member of the active Professional Staff appointed by the Chief of Staff. Duties of Supervisors of Associate Staff Members

A supervisor assigned to an associate staff member shall:

- a) Observe the member's performance of procedures and practice in the hospital.
- b) Review the member's charts and work in order to evaluate the competence of the associate.
- c) Guide and advise the member on Professional Staff organization and procedures, and
- d) Encourage the appropriate use of hospital resources, and

A supervisor shall immediately inform the Chief of Staff of any evidence of incompetence on the part of the Associate.

SECTION 1.04.01 REPORT OF SUPERVISORS OF ASSOCIATE STAFF MEMBERS

From time to time and at least every six (6) months during a probationary period, the supervisor shall make a written report to the Chief of Staff.

The report shall include:

- a) Comments on the knowledge and skill which has been shown by the Associate staff member.
- b) The nature and quality of the Associate's work in the hospital, including:

- i) Indications for and appropriateness of diagnosis and management.
- c) Comments on the Associate's quality of care and record keeping.
- d) Comments on the utilization of hospital resources.
- e) Comments on the Associate Staff member's ability to function in conjunction with other members of the Hospital Staff.

SECTION 1.05 ORIENTATION OF NEW PROFESSIONAL STAFF MEMBERS

All new members and/or applicants for membership to the Professional Staff must undergo an orientation within three weeks of appointment. This would include a general orientation to the facility and a more detailed one to the department or service concerned.

The Chief of Staff will be responsible for organizing the orientation in conjunction with the Chief Executive Officer or designate. This will involve Professional Staff, hospital management and/or other staff resources, and should include both clinical and facility orientation.

Examples of areas that should be covered are:

- Hospital mission vision and values
- Hospital by-laws, rules
- Departmental and service policies
- On call coverage requirements and procedures
- Emergency Preparedness i.e. Code Red, Orange, Green
- Information Technology
- Security and emergency numbers
- Professional Staff facilities and room numbering systems
- Cardiac arrest procedures
- Media Policy
- Health Information Management

All newly appointed Professional Staff will have an Occupational Health and Safety review and will comply with required submission of documentation around Communicable Disease Surveillance Protocols as recommended by PIDAC.

1.05.01 Code of Conduct

The Code of Conduct at GMCH and NWHC demonstrates our commitment to a safe, healthy and respectful workplace.

We value Compassion, Respect, Innovation, Professionalism, and Interprofessional Collaboration. By sharing our talent and resources, we can make a difference in the health status of the people whom we serve within our rural communities.

Contribute to a Teamwork Environment by:

- Actively participating, contributing and listening
- Cooperating - sharing resources and knowledge
- Acknowledging and accepting strengths and differences

- Partnering and building relationships to facilitate an open environment
- Gaining understanding for all roles within the organization and recognizing the value and contributions of each and being able to give and receive feedback from my interprofessional colleagues.

Professional staff are accountable for ensuring that her/his practice and conduct meets legislative requirements and competency standards for their profession and position. Professional staff pledge commitment to the code of behaviours to guide our day to day interactions and carry out the hospitals' values by:

- a) communicating effectively;
- b) contributing to a teamwork environment;
- c) displaying a positive attitude;
- d) demonstrating professionalism; and
- e) taking responsibility for your own individual leadership.

SECTION 1.06 PERFORMANCE AND STANDARDS OF PRACTICE

Annual reviews will be completed with the Chief of Staff for all Professional Staff with active and consulting privileges. This will take a form consistent with the standards of practice with the College of Physicians and Surgeons, Royal College of Dental Surgeons of Ontario and the College of Midwives of Ontario, and will involve a review of utilization, health records and feedback from team members. The procedure will be developed and updated in conjunction with hospital staff and MAC members as part of the quality program.

In order to ensure professional competency and familiarity with local resources, all professional staff must maintain an active clinical presence and familiarity with the facility that they are credentialed to.

Professional Staff will attend at least 50% of PSA meetings and of such other committees as they are members (policies already exist for discipline related to non-conformity with by-laws). In addition, members of Medical Staff shall attend 50% of Medical Staff meetings.

SECTION 1.07 CHIEF OF STAFF DUTIES

1. Provide leadership and direction to professional staff to ensure coordination of professional staff practice/hospital clinical practice. This includes responsibility for integrating professional staff goals and objectives into the hospital plans and overseeing resultant professional staff activities.
2. The GMCH/NWHC Chief(s) of Staff will work together and work with the JEC and the two hospital Medical Advisory Committees (MAC) to make recommendations on how to further integrate the professional staffs and the chief(s) of staff role(s), as well as recommend consequential changes to the professional staff by-laws, rules and regulations, and related credentialing policies and processes.
3. Provide leadership and direction to the quality and utilization management of professional staff activities in collaboration with the MAC and Safety, Quality and Performance Improvement (SQPI) Committee. In collaboration with the VP CNE, will advocate for and work to implement best practice models for patient care.
4. As an ex officio director of the Board, the Chief of Staff is required to regularly attend assigned committee meetings and adhere to the principles of the:
 - a) Board Policy 3-B-2 Code of Conduct;
 - b) Board Policy 3-B-6 Conflict of Interest.
 - c) Board Policy 3-B-9 Roles and Responsibilities of a Director

- d) Board Policy 3-B-10 Responsibilities of a Director
- 5. As Chair of the MAC, responsibilities include conducting the MAC meetings in accordance with *Nathan's Company Meetings including the Rules of Order* or such other rules of procedure adopted by the Board.
- 6. Fulfill the Chief of Staff responsibilities as expressed in the by-laws as follows:

GMCH & NWHC Part B Bylaw section 9.2 Responsibilities and Duties of Chief of Staff

- 1. The Chief of Staff shall:
 - (a) be an ex officio member of the Board/JEC
 - (b) be the Chair of the MAC;
 - (c) be an *ex officio* member of all MAC sub-committees; and
 - (d) report regularly to the JEC/Board on the work and recommendations of the MAC.
- 2. The Chief of Staff shall, in consultation with the Chief Executive Officer, designate an alternate to act during the absence of the Chief of Staff.

Furthermore, and to be more specific **The Duties of the Chief of Staff shall include:**

- (a) (refer to above By-law Section 9.2(b) and (d)) advise the MAC and the Board with respect to the quality of medical and dental diagnosis, and midwifery assessment, and care and treatment provided to the Patients of the Corporation; and extended class nursing care with respect to diagnosing, prescribing for or treating outpatients of the Corporation, is in accordance with policies established by the Board;
- (b) assign, or delegate the assignment of a member of the Professional Staff:
 - i) to supervise the practice of medicine with any other reciprocal member of the Professional Staff, or
 - ii) discuss in detail with other members of the Professional Staff, and
 - iii) make a written/verbal report to the Chief of Staff;
- (c) participate in Corporation resource allocation decisions;
- (d) participate in the development of the Corporation's mission, objectives, and strategic plan;
- (e) work with the MAC to develop the professional staff human resources plan needs of the Corporation in accordance with the Corporation's strategic plan and operational requirements;
- (f) ensure there is a process for participation in continuing Professional Staff education;
- (g) receive and review applications regarding changes in privileges;
- (h) receive and review applications for re-appointment. Ensure that the evaluations and recommendations are forwarded to the MAC; notify the Credentials Committee of the completion of the evaluations and the completion of the recommendation;
- (i) be an active participant on the following meetings/committees:
 - i) an ex-officio non-voting member of the JEC;
 - ii) a voting member of the SQPI Committee which meets approximately 5 times per year;
 - iii) the Incident Management Structure (IMS), in the case of emergencies (e.g. Code Orange, pandemic, etc.) to coordinate and support the professional staff response as required;
 - iv) the hospital's senior management team and participate in at least one meeting per month; and
 - v) the regional Chief of Staff; and
 - vi) other applicable meetings as is required.

The Chief of Staff is committed to the transformation of the health care delivery system (through Ontario Health Teams and regional Ontario Health/LHIN structures) and will work in partnership with their colleagues (internally and externally) to meet the overall health needs of the people we serve in our communities. Will

advocate for change to improve the patient experience and build resiliency.

SECTION 1.08 APPLICATION PROCESS

Section 1.08.01 Initial Application

Each application shall contain,

- i. a statement by the applicant that they have read and agrees to be bound by the *Public Hospitals Act* and the Hospital Management Regulation thereunder, and the By-laws and Professional Staff Rules of the Corporation;
- ii. an undertaking that, if they are appointed to the Professional Staff of the Corporation, they will govern themselves in accordance with the requirements set out in the By-laws, Professional Staff Rules and policies of the Corporation adopted or in effect from time to time;
- iii. evidence of membership in the Canadian Medical Protective Association or other evidence of medical practice protection coverage satisfactory to the Board with liability coverage appropriate to the scope and nature of the intended practice;
- iv. a list of the privileges which are requested;
- v. an up to date curriculum vitae;
- vi. a list of three (3) appropriate referees;
- vii. a completed immunization form;
- viii. disclosure of any conviction for a criminal offence relevant to the practice of medicine for which a pardon has not been granted;
- ix. information of any previous disciplinary proceeding where there was an adverse finding;
- x. disclosure of any civil lawsuit where there was a finding of negligence or battery or a payment made by way of settlement;
- xi. a signed consent authorizing any medical regulatory body or referee to provide a report on,
 - (i) any adverse findings by its disciplinary or fitness to practice committee, and
 - (ii) whether they Privileges have been curtailed or cancelled by any medical regulatory body or by another hospital because of incompetence, negligence, incapacity or any act of professional misconduct;
- xii. a current certificate of Professional Conduct from the College of Physicians and Surgeons of Ontario, College of Nurses of Ontario, Royal College of Dental Surgeons of Ontario, or the College of Midwifery of Ontario and consent to the release of information from the Registrar of the College; and
- xiii. a signed offence declaration form.

1.08.02 Reappointment Application

The reappointment process consists of the following:

- (i) Completion of the online re-appointment application
- (ii) Payment of the hospital re-appointment fee (\$75)
 - a. Late fee is charged in the amount of \$250 in addition to the \$75 re-appointment fee if the online re-application is received past the due date.
- (iii) Payment of Medical Staff Association dues (as appropriate)
- (iv) Attachment of supporting documentation:
 - a. Proof of liability insurance (CMPA, HIROC, etc.)
 - b. Proof of Licence (CPSO, COM, RCDSO, etc.)
- (v) Other requirements:
 - a. Signed applicant's acknowledgment
 - b. Signed confidentiality agreement
 - c. Signed authorization for medical directives (if applicable)
- (vi) Completion of the following mandatory training course:
 - a. Privacy education

If the re-application is not completed by June 30th, it will be assumed that the professional staff does not wish re-appointment and will be removed from the professional staff listing.

SECTION 1.09 HOSPITAL COMMITTEES

The following Committees of the MAC are hereby established:

- (i) Credentials Committee,
- (ii) Medical Records and Utilization Committee,
- (iii) Infection Control Committee,
- (iv) Pharmacy and Therapeutics Committee, and
- (v) such further and other Committees as may be required, from time to time, for the supervision, review and analysis of all the work required to be supervised, reviewed or analyzed by the MAC, or to address such issues as may be prescribed by the Hospital Management Regulation or the Board from time to time.

All committees appointed by the MAC shall meet as directed by the MAC and as otherwise established in these Rules and Regulations.

All committees reporting directly or appointed by the MAC shall present a written report including any recommendations of each meeting to the next meeting of the MAC.

A committee chairperson may request a meeting with the MAC or, at the request of the MAC, shall be present to discuss all or part of any report of that committee.

Committee co-chairs with disputes shall be referred to the Chief of Staff for resolution.

Appointment to Medical Advisory Committee subcommittees

- (A) The Medical Advisory Committee will appoint the members of each subcommittee. Normally members will be appointed for a three-year term.
- (B) All membership appointments will be reviewed and confirmed by the Medical Advisory Committee on an annual basis.
- (C) All Medical/Professional Staff members are eligible for appointment to a Medical Advisory Committee subcommittee.
- (D) The Chief of Staff will be an ex-officio voting member of each subcommittee, and have the power to send a voting delegate to a meeting.
- (E) In the event of a vacancy on a subcommittee, the Medical Advisory Committee may appoint a replacement to complete the remainder of the term.
- (F) Appointment of Chair of Medical Advisory Committee Subcommittees
 - i. The Medical Advisory Committee will appoint the chair of each subcommittee.
- (G) Duties of the Chair of a Medical Advisory Committee Subcommittee
 - The chair of a subcommittee:
 - i. will call meetings of the subcommittee;
 - ii. will chair the subcommittee meeting;
 - iii. at the request of the Medical Advisory Committee, will discuss all or part of any report of the subcommittee;
 - iv. may request meetings with the Medical Advisory Committee.

Medical Advisory Committee Subcommittee Requirements

- (A) In addition to the specific duties of each subcommittee, all subcommittees will:
 - i. hold the number of meetings specified in their terms of reference;
 - ii. circulate copies of the minutes to the members of the subcommittee, and to the Medical Advisory Committee as appropriate;
 - iii. where a subcommittee wants to make a recommendation to the Medical Advisory Committee, prepare a written report, including any recommendations and forward it to the Medical Advisory Committee; and
 - iv. maintain a record of attendance of subcommittee members.

Medical Advisory Committee Subcommittee Powers and Duties

- (A) Each subcommittee will:
 - i. Recommend to the Medical Advisory Committee matters that fall within their area of responsibility and recommend changes and/or amendments to the Rules and Regulations.

- ii. Have the right to conduct a review of any health record, when required to fulfill its duties and functions;
- and iii. Review matters within its area of responsibility or are referred by the Hospital administration and/or the Medical Advisory Committee and report to the Medical Advisory Committee as may be required or considered advisable.

Hospital operational committees will be co-chaired with representation by a physician lead and a clinical staff member.

SECTION 1.09.01 CREDENTIALS COMMITTEE

1) The Credentials Committee of the MAC may be composed of one (1) or more members of the MAC or may be composed as a Committee of the whole MAC.

2) The Credentials Committee shall:

- i) meet annually, and more often as required, to review applications for appointments and re-appointments to the Professional Staff of the Hospital;
- ii) ensure that a record is kept of the qualifications and professional career of every member of the Professional Staff in accordance with any applicable legislative or regulatory requirements relating to confidentiality;
- iii) investigate the professional experience, competence, reputation, ability to work with others and establish the authenticity of the qualifications of:
 - i) each applicant for membership on the Professional Staff of the Hospital;
 - ii) each applicant for changes in Privileges; and
 - iii) each applicant for re-appointment to the Professional Staff of the Hospital;
- iv) assess the suitability of a Professional Staff's application for appointment or re-appointment to the Staff of the Hospital in accordance with the criteria established in these Professional Staff Rules and Regulations and the By-laws;
- v) consider, in making a recommendation regarding appointment, the interviews with the applicant required by the By-laws;
- vi) ensures an Impact Analysis has been performed on all new applicants (*Appendix 3 (New & Expanded; Appendix 4 Replacement or Addition)*);
- vii) submit to the MAC, at or before its next regular meeting, a report of the findings made under subsection (iii), together with the Credentials Committee's report as to whether or not the application meets the established criteria, as laid down by these Professional Staff Rules and Regulations and the By-laws;
- viii) report to the Board, before June 30th, as to the matters described in subsection (vii);
- x) recommend to the MAC, after consultation with the appropriate member of the consulting or active staff, the staff category of appointment and assigned, according to their qualifications and experience;
- xi) perform any of the duties prescribed by the MAC.

SECTION 1.09.02 MEDICAL RECORDS AND UTILIZATION COMMITTEE

The Medical Records and Utilization Committee combines the medical records functions and utilization to promote a seamless process involving utilization of resources.

The membership represents physician and hospital personnel to enable timely action to improve utilization and patient care, as follows:

- Physicians (2) must include a member of MAC
- Manager Health Information
- Manager(s) of Patient Care
- Registered nurse (1)
- CCAC Representative(s)
- VP Corporate (or Designate)
- VP Patient Services (ad hoc)
- Quality and Risk Manager (ad hoc)

The Medical Records and Utilization Committee shall meet quarterly or at the discretion of the chair.

MEDICAL RECORDS AND UTILIZATION COMMITTEE DUTIES

The Medical Records and Utilization Committee shall ensure routine dissemination of information to MAC, department managers/administration, and chief of staff for operational management and ensure that the regulations under the *Public Hospitals Act*, the Corporation By-laws and the Professional Staff Rules are observed, including:

- Routinely review, analyze and monitor utilization data and disseminate utilization information throughout The Hospital to ensure and improve the efficient and effective use of resources;
- Uses analysis and benchmarking to identify, evaluate and recommend utilization improvement strategies to the respective manager, administrative team and MAC;
- Establishes ad-hoc working groups to address specific utilization issues/opportunities and monitors and reports on the effectiveness of utilization improvement initiatives;
- Provides assistance and advice to Health Information Services to ensure timely and accurate completion of the health records, and the appropriate documentation including regular review of clinical documentation to ensure compliance with standards as set by peers and legislation;
- Ensures that the MAC and hospital are made aware if the requirements of the Public Hospitals act are not being met with respect to health records including record retention and establish policies and procedures that monitor compliance;
- Support the advancement of the electronic health record; and
- Reviews and recommends to MAC all proposed changes to forms and documents intended to become part of the health record.

SECTION 1.09.03 INFECTION CONTROL COMMITTEE

The Infection Control Committee shall consist of medical staff representative(s), senior management representative, Laboratory representative(s), Infection Prevention and Control Professional(s) Occupational Health representative, Departmental representative (s) of Nursing, OR/CSR, Support Services, Public Health representative(s), Pharmacy representative (ad hoc), Pathologist (ad hoc).

The Infection Control Committee shall hold four meetings per year or at the discretion of the Chair.

This committee reports to MAC, Safety Quality Performance and Improvement (SQPI) and Senior Management Team (SMT).

INFECTION CONTROL COMMITTEE DUTIES

The Infection Prevention and Control Committee reviews and recommends procedures and practices pertaining to Infection Prevention and Control. The goals of the infection prevention and control program are to protect patients from health care associated infections and to prevent the spread of infections from patient to patient, from patients to health care providers, from health care providers to patients, from health care providers to health care providers and to visitors and others in the health care environment using best practice guidelines.

- Manage critical data and information including surveillance for nosocomial and other infections.
- Make recommendations for implementation of evidence based practice, standards and guidelines through policies and procedures including but not limited to hand hygiene, reprocessing, construction and renovation, environmental cleaning, routine practices and additional precautions.
- Direct interventions to prevent the transmission of infections, including outbreak prevention and control.
- Direct effective occupational health programs including immunization services.
- Make recommendations for educating and training health care providers, patients and their families.
- Communicate infection related issues and relevant practices to leaders and staff to facilitate improvement.
- Monitor, evaluate and make recommendations for improvement of the Infection Prevention and Control Program and surveillance system.

SECTION 1.09.04 PHARMACY AND THERAPEUTICS COMMITTEE

The Pharmacy and Therapeutics Committee membership shall consist of medical representatives, Specialists, Family Practice, Managers of Patient Care, Clinical Resource Nurses, Vice President Clinical Services/CNE (ad hoc), Pharmacist, Pharmacy Staff and Chief of Staff (ex-officio).

The Pharmacy and Therapeutics Committee shall hold at least eight (8) regular meetings annually and such additional meetings as may be required.

PHARMACY AND THERAPEUTICS COMMITTEE DUTIES

The Pharmacy and Therapeutics Committee provides an Inter-professional forum to oversee the systems which promote the safe, effective and efficient use of drugs.

The Pharmacy and Therapeutics Committee shall make recommendations to the MAC including:

- Maintain a formulary of drugs that are approved for use in hospital and undertake critical evaluations of all requests for changes to the formulary.
- Review and approve medication-related policies, procedures, best practices and standards of practice in order to promote the safe, effective and economical use of medications.
- Review and approve:
 - Drug Use Guidelines.
 - Policy Related to the Administration of Parenteral Drugs.
 - Clinical Practice Guidelines (that include drug therapy)
 - Clinical Pathways (that include drug therapy)
 - Develop, review and update Patient Order Sheets
- Identify educational programs required for staff on pertinent matters related to drugs and their use.
- Review Quality/Risk Management reports including adverse drug reaction reports regarding high risk or potential high risk medication errors, their causative factors and make recommendations for error prevention.
 - Review minutes and approve the recommendations to be forwarded to the Medical Advisory Committee.

SECTION 1.10 LEAVE OF ABSENCE

Many leaves are managed through locum coverage, vacation or other informal arrangements that are not brought to the attention of the board.

However, if a hospital proposes to suspend or restrict a Professional Staff member's privileges during the leave of absence, the board must be involved in those decisions.

Refer to GMCH and NWHC Part B Professional Staff By-laws Section 4.10 Leave of Absence for additional information regarding members requesting a leave of absence.

SECTION 1.11 PREGNANCY/PARENTAL LEAVE

(a) Pregnancy/parental leave benefits for Medical/Professional Staff members who are employees of the Hospital are outlined in the relevant employee policies, as amended from time to time.

(b) Medical/Professional Staff members who are not employees of the Hospital may request pregnancy/parental leave by applying for a leave of absence and, if approved, will:

- (i) not be required to serve on-call;
- (ii) arrange for coverage of in-Patients during the leave; and
- (iii) not be required to completely cease clinical activity at the Hospital.

(c) The Medical/Professional Staff member and Hospital leadership will endeavor to work together to arrange for coverage of the Medical/Professional Staff member's Hospital responsibilities.

(d) When coverage is intended to be provided by a Physician/Dentist/Midwife who is not a Medical/Professional Staff member, the following will apply:

- (i) the Physician/Dentist/Midwife will apply for Locum Tenens Staff Privileges; and
- (ii) if granted such Privileges, the Physician/Dentist/Midwife is expected to fulfill the role of the Medical/Professional Staff member in all clinical respects unless alternative, mutually agreeable terms of service have been developed.

(e) A Medical/Professional Staff member on pregnancy/parental leave will be expected to return to the same clinical duties and the same access to resources that were in place at the commencement of their leave unless the Medical/Professional Staff member wishes to negotiate alternative, mutually agreeable terms of service.

(f) Should circumstances arise before, during, or after the leave that may impact the clinical duties and/or access to resources, effort will be made to include the Medical/Professional Staff member in relevant discussions.

SECTION 1.12 EXTENDED CLASS NURSING PRIVILEGES

Extended Class Nursing Staff are allowed access to hospital-based services within their scope of practice.

ARTICLE II. ADMISSION OF PATIENTS

SECTION 2.01 GENERAL ADMISSION RULES

All physicians, midwives, RN Extended Class, and oral surgeons shall be governed by the Admitting and Transfer Guidelines procedures of the hospital.

No patients shall be admitted to the hospital except by an order of a Professional Staff, with Active, Associate or Courtesy with admitting privileges.

The admitting practitioner shall provide orders upon the patient's admission. These orders may accompany the patient to the hospital at the time of admission. All orders must be dated and signed.

No patient shall be admitted to hospital until after a provisional diagnosis has been recorded.

SECTION 2.02 ADMISSION PRIORITIES

The Manager of Patient Care/Clinical Resource Leader/Charge Nurse or delegate will assign patients to beds on the basis of medical condition and bed availability.

ARTICLE III. CONTINUITY OF MEDICAL COVERAGE

SECTION 3.01 ATTENDANCE OF PATIENTS

There will be a Most Responsible Physician (MRP) identified for each patient.

Whom the MRP is shall be determined according to The Hospital MRP Policy. The Most Responsible Professional (MRP) Staff will co-ordinate the care of the patient in accord with the following:

- a) Make daily visits to admitted acute care patients and participate in patient care rounds.
- b) Respond by telephone within 15 minutes for new or continuing medical problems. If the MRP or designate cannot be reached, the Chief of Staff or delegate shall be called.
- c) Respond to urgent patient problems.
- d) Maintain either verbal or written active communication with the Professional Staff and other care providers involved in care of the patient.
- e) Communicate with the patient's family
- f) Progress notes on acute care patients should be written daily to accurately reflect the changing clinical condition of the patient and outline the plan of care.

A patient is in the acute phase of illness until an Alternate Level of Care (ALC) is designated. Patients may be designated ALC by a physician. ALC designation form must be signed by a physician.

Should it be necessary, the Chief of Staff shall have the authority to call any appropriate member of the staff to attend the patient.

SECTION 3.02 TRANSFER OF CARE

Transfer of care to a new MRP shall be documented in the patient's record. The previous and new MRP must both agree to the transfer, preferably through conversation regarding the patient transfer.

SECTION 3.03 TRANSFERS OF CARE – OBSTETRICS

If an obstetrical patient with a viable term fetus presents to the hospital in labour or with membranes ruptured the practitioner identified as responsible for her obstetrical care (usually the on call physician for OB or family physician or midwife) will be contacted. If there is failure to contact them

[or their delegate] within a reasonable time of half an hour, or more urgently if the situation presents, the hospital back-up physician or ED physician will be contacted automatically.

SECTION 3.04 TRANSFER OF CARE - ON CALL

The physician on call for the hospital shall assume responsibility for all inpatients after office hours and on weekends and holidays as per The Hospital MRP Policy.

SECTION 3.05 FAILURE TO COMPLY WITH REQUIREMENTS

When a Professional Staff fails to meet the commitments noted above, the On Call Professional Staff will ensure that appropriate Professional Staff care is provided, and:

- a) The Professional Staff On-Call will advise the Chief of Staff of the noted failure.
- b) The Medical Advisory Committee will consider and decide the matter at its next regular meeting.

SECTION 3.06 TRANSFER OF CARE – ARRANGED ABSENCES

Each Professional Staff who will be absent from the hospital due to vacation, education or other cause, will arrange for the transfer of care of his patients to an alternate Professional Staff who has appropriate privileges.

A note will be placed on the chart of each patient being transferred, recording the transfer.

SECTION 3.07 PARTICIPATION IN THE ON-CALL ROSTER

Professional Staff on active and associate staff shall arrange a roster ensuring constant availability of a Professional Staff to attend inpatients and outpatients. The Professional Staff on call shall be available on phone within fifteen minutes and in person within thirty minutes. If the traveling time from the physician's residence is greater than the stipulated timeframe, then the physician should consider utilizing the on-call sleep room within the hospital.

ARTICLE IV. GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

SECTION 4.01 EMERGENCY SITUATIONS

All practitioners, regardless of level of privileges, shall render assistance in an emergent situation.

SECTION 4.02 CONSULTATIONS

Any practitioner with privileges in the hospital must respond to a request for consultation within their area of privileges as sanctioned by the Board of Directors.

The attending practitioner customarily initiates consultation requests when indicated. This request must stipulate whether it is a consultation or a transfer of care. The requesting practitioner is ultimately responsible for the appropriate communications with the consultants.

SECTION 4.03 MONITORING PRACTICE

Where any member of the Professional Staff or Hospital staff believes that a member of the Professional Staff is attempting to exceed the member's privileges or is temporarily incapable of providing a service that the member is about to undertake, the belief shall be communicated immediately to the Chief of Staff and to the Chief Executive Officer.

SECTION 4.04 MEDICAL RESIDENTS AND STUDENTS

Medical Residents and Students (Trainee) shall abide by the Medical Residents/Students in Hospital By-laws and Hospital Policies. Must attend orientation including privacy education and sign the pledge of confidentiality.

From time to time, a Professional Staff/medical student enrolled in a graduate or post-graduate medical training at a recognized medical school may be granted temporary resident/medical student Privileges at the Hospital for the purpose of furthering their education and specifically to further their education in rural medicine.

When granted temporary resident/medical student Privileges, such a Professional Staff/medical student must have a designated Supervisor.

The designated Supervisor must be a member of the active or consulting Professional Staff in good standing and be accepted by the Medical School.

In order for a resident/medical student to be accepted for a medical education training placement the Resident's/Medical Student's Medical School must provide a letter of good standing outlining the following: name of student, student #, student's year of training, name of training program, name of The Hospital designated supervisor, dates of training, confirmation of immunization screening is up-to-date, confirmation of mask fitting, and signature of program director. In the case of Medical Resident's, the letter of good standing must also include CPSO and CMPA #.

All Medical Residents/Students will sign:

- a statement attesting to the fact that they have read the subsection below, and agree to abide by the stipulations thereof.
- Code of Conduct and Confidentiality Forms.

Where the resident/medical student is taking part in a post-graduate medical specialty training program and is the holder of an educational or general licence and is under the supervision of a member of the consulting Professional Staff of the Hospital, whose primary practice is at another hospital, the **Credentials Committee Chair and/or Chief of Staff or CEO** will review and recommend the granting of, or reject, the requested Privileges by the Board based on copies of the credentialing documents provided by the secondary care or tertiary care hospital, if accompanied by copies of:

- the application,
- letter or motion recommending the granting of temporary resident Privileges, and
- a copy of the liability agreement or affiliation agreement.

Medical Student/Clerk Roles and Responsibilities (Medical Students are in the preclinical phase of medical school and Medical Clerks are in the clinical phase of medical school)

The following outlines the activities in which the clinical clerk will be involved: Clinical

Clerk:

- Is granted a clinical placement under the preceptorship of active Professional Staff.
- Is NOT a Professional Staff and will not be addressed as Doctor.
- Documents on patient history, physical examination, diagnosis and progress notes.
- Documentation must be reviewed and countersigned by the attending Professional Staff or a licensed Professional Staff responsible for the care of the patient.
- May write “orders” concerning investigation or treatment of a patient under direct supervision of a licensed Professional Staff and must be countersigned by that Professional Staff.
- Within the principles of graded responsibility, a clinical clerk may carry out technical procedures under direct or remote supervision, depending on level of competence. In the case of remote supervision, the procedures shall be restricted to those which a registered nurse is permitted to perform after special instruction and designation with the College’s Policy on Special Procedures by Nurses.

Services Permitted:

- Access to patient chart.
- Patient access – observing and listening, history and physical with/without preceptor present.
- Therapeutic Procedures (subject to fulfilling surgical scrub requirements) – observing (all areas) and assisting all areas with supervised performance.
- Meeting attendance – education, departmental and committee.
- Most Responsible Physician Policy - provides guidelines to ensure questions about patient care are attended to.

Medical Residents Roles and Responsibilities (Medical Residents are designated by the acronym PGY and a number indicating which post-graduate year they are completing)

Residents’ experiences will include:

- Working in the office with their supervisor
- Seeing inpatients and outpatients at the hospital
- Covering ER with the doctor-on-call
- Assisting in the OR
- Assisting with procedures as they arise in the hospital
- Rounds with other Professional Staff.
- As a Professional Staff with an educational license, residents may assess and manage patients, write orders (including scripts) and perform procedures. The supervising Professional Staff and resident will determine the level of supervision required. Once a level of comfort is established with skills in an area of care, supervision may consist of review, following care given, with the supervising Professional Staff. Other members of the team

play an important supportive role in this learning environment. If concerns arise in specific situations, then it may be suggested to a Resident that the supervising Professional Staff be consulted.

- Most Responsible Physician Policy - provides guidelines to ensure questions about patient care are attended to.

ARTICLE V. TRANSFER OF PATIENTS

SECTION 5.01 INTERNAL TRANSFERS AND BED ASSIGNMENT

Internal transfer refers to the transfer of a patient from one level of care to a different level of care. Bed assignment is done by the bed allocation and nursing staff and include other factors such as availability of beds.

The initial bed assignment shall ensure that hospital staff can carry out the orders as written by the practitioner. Patients may be transferred to alternate levels of care within the hospital as long as the patient orders, as written, can be safely carried out

In the event that the patient's condition has improved and, in the judgment of the nursing staff, the patient may be transferred to an alternative level of care (ALC), the Most Responsible Practitioner shall be consulted.

SECTION 5.02 EXTERNAL TRANSFER TO ANOTHER FACILITY

Patients shall be transferred to other appropriate facilities,

- When in the judgment of the practitioner and nursing staff, the level and/or type of care required by the patient cannot be provided at the Hospital.
- Where possible, at the request of the patient and family.

When transfer to a higher level of care is anticipated to be required, the MRP will contact CritiCall where appropriate to assist with the process of matching the patient to the appropriate level and site of care.

The MRP shall be responsible for communicating with the receiving practitioner who will accept the patient in transfer. The name of the receiving practitioner as well as specific orders pertaining to the care of the patient during transfer shall be provided to the nursing staff.

SECTION 5.03 TRANSFERS FROM ANOTHER FACILITY

The hospital will only accept transfers from other facilities that have been accepted by a practitioner with admitting privileges.

Transfers may only be accepted under the following conditions:

- The hospital is capable of caring for the patient and the associated illness/injury. This includes the availability of staff, beds and necessary resources.

ARTICLE VI. DISCHARGE OF PATIENTS

SECTION 6.01 FOR SURGICAL ELECTIVE PATIENTS

All elective surgical patients at high risk for medical complications American Society of Anesthesiologists [(ASA)(class 3+)] should be assessed by anaesthesia prior to surgery as per The Hospital policies.

SECTION 6.02 FOR ALL OTHER PATIENTS

The admitting doctor will provide an estimate as to expected length of stay (ELOS) at the time of admission.

It is the responsibility of the MRP to work with the inter-professional team, community agencies and/or practitioners to coordinate the discharge.

A discharge order must be specific as to the date of the discharge or with specific conditions to be met prior to discharge.

Patients shall be discharged only on the order of the MRP or on-call Professional Staff. The discharging Professional Staff shall complete the health record and complete a discharge summary.

Whenever possible, patients and their families shall be informed of anticipated discharge twenty-four (24) hours in advance.

When appropriate, a responsible practitioner should be identified who will provide follow-up care for each patient discharged from the hospital. If that practitioner was not involved in the care of the patient during the hospitalization, the most responsible practitioner should inform the practitioners as to the course of the patient's hospitalization, the patient's discharge date, medications, and need for continuing care.

SECTION 6.03 LEFT AGAINST MEDICAL ADVICE

If the patient insists upon leaving the hospital against the advice of the attending Professional Staff, they shall be informed of the consequences of doing so. If the Professional Staff is present, a statement describing the circumstances shall be entered by the Professional Staff in the patient's medical record; where the Medical/Professional Staff member is not present, a statement describing the circumstances shall be entered by the most responsible nurse in the health care record and the MRP shall be informed. Whenever possible, the patient shall be asked to sign a release form.

ARTICLE VII. ORDERS

SECTION 7.01 GENERAL REQUIREMENTS

Orders may be given by credentialed staff only. Verbal orders will be given in emergency situations only. Telephone orders will be signed as per The Hospital policy. Orders must be legible. All orders must be dated, timed and recorded on the patient's record. It is the responsibility of professional staff to ensure all orders are signed. Coordination of care between practitioners is the responsibility of the MRP.

Professional Staff shall comply with the Patient Care Order Policy & Procedure. With respect to drug orders, the Prescribing and Dispensing Policies and Procedures approved by the Pharmacy and Therapeutics Committee shall govern the practice of practitioners.

The MRP shall be responsible for any orders written by medical residents or student practitioners.

SECTION 7.02 SPECIAL ORDERS

(a) Advanced Care Planning

Physicians should discuss advanced care planning including resuscitation status when appropriate and document on chart.

(b) Day Passes

Practitioners shall be familiar with and abide by the Day Pass Policy and Procedure.

(c) Least Restraints

As outlined by the Least Restraints Policy in the Inter-professional Patient Care Manual, Professional Staff shall assess patients and order continued use of restraints.

(d) Medical Directive

It is a directive for a procedure, treatment, drug or intervention and may be implemented for a range of patients when specific conditions are met, and when specific circumstances exist. A medical directive is always written and documented on the Patient Care Record.

(e) Telemetry Orders

The need for telemetry monitoring must be reassessed every 24 hours.

(i) Oxygen Orders

Oxygen is a drug and may only be administered to a patient with an order from a practitioner except in emergency situations or by Medical Directives.

(j) Fax/Other Electronic Transmission Orders

Any orders faxed or distributed by any other electronic means must conform to a format approved by The Hospital and the Medical Advisory Committee.

ARTICLE VIII. HEALTH RECORDS

SECTION 8.01 GENERAL

The health record is the documentation of the patient's course at the hospital and is considered a major means of communication among health care providers. Health records shall be written in a legible manner with a means of easily identifying the author.

All practitioners shall comply with the Patient Record Completion Policy.

SECTION 8.02 CONTENT

The completed patient record shall comply with the standards outlined in the Public Hospitals Act and according to Hospital policy and procedure.

SECTION 8.03 ADMISSION HISTORY AND PHYSICAL

A practitioner with admitting privileges shall document a complete admission history and physical examination within twenty-four (24) hours of admission.

If a practitioner wishes to use a consultant's report as the complete history and physical examination in the chart, the MRP must state in the admission note that the consultation record is acceptable to the MRP as representing the complete record.

The OMA/MOHLTC antenatal record shall serve as an admission history and physical for all obstetric deliveries.

SECTION 8.04 PRE-ADMISSION DOCUMENTATION

Where documentation on a pre-admission history, physical examination and provisional diagnosis is accepted by the practitioner and put in the health record, the MRP must write, date, and sign in the health record after admission that the pre-admission documentation accurately reflects the patient's current clinical condition. If there is any change, it shall be noted in the health record.

SECTION 8.05 PROGRESS NOTES

Progress notes should be written daily during the acute phase of illness to accurately reflect the changing clinical conditions of the patient. Each entry shall indicate the time, date, and relevant impressions and the plan by the most responsible practitioner.

A hand-over sheet or note shall be completed whenever there is going to be more than a 24 hour period before the attending practitioner will be present and the on-call Professional Staff is expected to be MRP.

SECTION 8.06 PRE-OPERATIVE DOCUMENTATION

For all surgical procedures involving an anaesthetist there will be:

A completed history and physical examination with a provisional diagnosis.

On the consultation form in referred surgical cases, a record of the surgeon's findings and recommendations, or in lieu of consultation, the surgeon may complete the history and physical examination. In addition, the surgeon will enter or cause to be entered the pre-operative diagnosis on the operative sheet before commencing the operation. This excludes Outpatient procedures.

The record of surgical consultation, when performed, shall be in evidence on the health record prior to anesthetic induction.

In emergency situations, the documentation of the history and physical examination may be provided post-operatively within twenty-four (24) hours.

In the case of a patient in the Emergency Department requiring emergency surgery, the Emergency Record History and Physical will be valid as a pre-op report for twenty-four (24) hours.

The Surgical Safety Checklist will be completed on all surgical patients.

SECTION 8.07 OPERATIVE REPORTS

Following surgery, the surgeon will enter a note in the progress record noting pertinent information regarding the surgery performed which will serve as documentation of the procedure performed until a dictated or full hand-written report is available.

The surgeon shall complete the operative report as soon as possible but not later than twenty-four (24) hours after completion of surgery.

All procedures in the operating room or endoscopy suite which require anesthesia will be recorded on an operative report.

Operative reports and reports of invasive and non-invasive procedures performed by a practitioner shall include a statement of the indications for the procedure and a detailed account of the findings; including, compliance to the Surgical Safety Checklist.

The operative report shall contain:

- A description of the findings;
- The technical procedure used;
- Specimens removed;
- The post-operative diagnosis;
- The name of the primary surgeon and any assistants/residents/clinical clerks.

SECTION 8.08 DIAGNOSTIC PROCEDURES OUTSIDE OF THE OPERATING ROOM

Invasive diagnostic procedures performed outside of the Operating Room requiring practitioner interpretation, shall include a written or dictated statement of indications and findings within twenty-four (24) hours of the procedure.

SECTION 8.09 ANESTHETIC REPORT

Pre-anesthesia evaluation will be documented on each patient for whom anesthesia is contemplated. The post-operative status of the patient must be evaluated and documented on admission to and discharge from the post-anesthesia recovery area. Any unusual events or post-operative complications and management of those events shall be recorded.

SECTION 8.10 DISCHARGE SUMMARY

The discharge summary shall consist of a summary of the patient's course in hospital as well as follow up care when relevant as indicated in the Patient Record Completion Policy.

SECTION 8.11 ABBREVIATIONS

Practitioners shall only use Hospital approved abbreviations.

SECTION 8.12 DOCUMENTATION REQUIREMENTS

All practitioners delinquent with respect to the Health Records Policies shall be subject to loss of privileges as outlined in the chart completion policy.

SECTION 8.13 CHART DEFICIENCY MANAGEMENT

Members of professional staff shall follow the Patient Record Completion Policy. Patient Record Completion Policy outlines responsibility and timelines for record completion including requirements for chart completion, authentication, overdue record management and suspension of privileges.

SECTION 8.14 SUSPENSION OF PRIVILEGES

Admitting privileges both inpatient and outpatient may be suspended until such time as all outstanding records have been completed. Professional staff may continue with ER shifts and emergency admissions but may not become the MRP on new admissions. The professional staff is required to communicate suspension with any patient where care is transferred. Physicians may continue to treat patients who are already in the hospital. Obstetric patients are not affected by the suspension. All booked (elective) procedures will be cancelled until privileges are reinstated.

It is the responsibility of the individual Professional Staff and the Chief of Staff to guarantee that patient care is not jeopardized during a suspension of privileges.

Reinstatement of Privileges: When all records are completed and Health Information staff have confirmed completion, privileges are reinstated.

ARTICLE IX. CONSENTS

SECTION 9.01 INFORMED CONSENT

Except in certain emergency situations, as described in the Consent to Treatment Policy, a Professional Staff is required to obtain consent from a patient before providing treatment.

SECTION 9.02 CONSENT POLICY

Professional Staff Requirements for Consent to Treatment are detailed in the Consent to Treatment Policy.

ARTICLE X. DELEGATED MEDICAL ACTS

SECTION 10.01 CONTROLLED ACTS AND DELEGATION

Any practitioner can delegate, in whole or in part, controlled acts ascribed to their profession by the Regulated Health Professions Act (RHPA).

SECTION 10.02 MEDICAL DIRECTIVES

Medical Directives must be approved by the Medical Advisory Committee.

ARTICLE XI. HOSPITAL DEATHS AND AUTOPSIES

SECTION 11.01 PRONOUNCEMENT OF DEATH

In the absence of Professional Staff, a Registered Nurse has the authority to pronounce death on expected deaths. This pronouncement allows the body to be moved to the morgue. If a post mortem is to be performed and/or if a coroner is involved, the body must go to the morgue in the state it is in at the time of death. All tubes, lines and dressings should remain in place.

SECTION 11.02 CERTIFICATION OF DEATH

The physician called to pronounce death or the MRP shall complete the medical certificate of death within 24 hours. A copy is filed in the health record.

Where a coroner is involved in a patient's death, the coroner will complete the medical certificate of death. When a copy of the medical certificate of death is not available, then a Form 1, Public Hospitals Act Certificate of Death, will be completed by the most responsible physician and filed on the chart.

SECTION 11.03 AUTOPSIES

In the absence of a coroner's involvement, it is the responsibility of the most responsible physician to discuss the need and consent for an autopsy with the family. The family must be made aware that the autopsy expenses will be their responsibility. If it is a coroner's case, the autopsy is conducted as part of the investigation.

SECTION 11.04 CORONER'S CASES

Coroner's cases are mandatory in circumstances; such as: suspected criminal activities, motor vehicle accidents, and unusual circumstances. For more information please refer to this link:

http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90c37_e.htm

ARTICLE XII. ORGAN DONATIONS

SECTION 12.01 STATEMENT

The responsibility to ensure the availability of organ and tissue transplantation is shared among governments, health institutions, health professionals and the general public. The primary obligation of practitioners is to their individual patients and this takes precedence over any family interests.

SECTION 12.02 CONSENT

In approaching the family for consent for organ and tissue donation, the practitioner must provide accurate information and support the family regardless of what decision is made.

SECTION 12.03 PROCEDURE

The procedure for organ and tissue procurement is documented in the hospital policy for Organ and Tissue Donation

ARTICLE XIII. BLOOD AND BLOOD PRODUCT ADMINISTRATION

Blood and blood product administration will follow Inter-professional Policy and Procedure Manual and Ontario Regional Blood Coordinating Network (ORBCoN) Guidelines.

ARTICLE XIV. INFECTION CONTROL

All practitioners shall be aware of and comply with the Infection Control policies and procedures as contained in the Inter-professional Policy and Procedure Manual.

ARTICLE XV. COMPLAINT RESOLUTION

SECTION 15.01 PREAMBLE

The Professional Staff, as part of its self-governance, has a duty to respond to complaints or concerns that are directed towards its members. The Chief of Staff is charged by the Board to report on quality of care as well as resource utilization concerns. Performance encompasses quality of care, resource utilization, and professional behavior.

Complaint resolution should be conducted in a way that emphasizes objectivity, accountability, fairness, and follow-up expectations. Encounters should not be construed by either party as adversarial but, instead, as constructive interactions.

This procedure acts as a guideline and is not meant to supplant the process outlined in the Professional Staff Bylaw for the mid-term suspension and revocation of privileges, nor that detailed in the hospital's Zero Tolerance to violence. If conduct comes under the behavior defined in the Zero Tolerance to violence, then it will be dealt with accordingly. If the complaint is to be dealt with as a matter going to hospital privileges, then the procedures mandated by the Public Hospitals Act and the jurisprudence applicable to these procedures and the hospital's by-laws will be followed.

It is recognized, however, that there are situations where such a formalized process need not be entertained. It is also recognized that the following procedure need not be followed in each and every instance that a complaint is received. The procedure that follows is meant to provide Administration and members of the MAC with a guideline for the handling of complaints lodged against practitioners.

The following steps are suggested to address complaints that have, directly or indirectly, implicated practitioners:

SECTION 15.02 GUIDELINES FOR COMPLAINT OR ADVERSE EVENT RESOLUTION

The practice of Medicine, Midwifery, Dentistry, Extended Class Nursing will from time to time lead to unexpected adverse events, conflict with coworkers and complaints from staff and public. It is the duty of the Chief of Staff to deal with such issues. At all times an attention to improving patient well-being is paramount.

Adverse Events:

The Chief of Staff in conjunction with Chief Nursing Executive (CNE) may investigate adverse events. Information may come from the Manager of Quality and Risk, hospital safety, quality and performance improvement committee or from sub-committees with responsibilities to monitor facets of hospital care (e.g. emergency, surgical, perinatal, inpatient services). The Chief of Staff may delegate the task of investigating such events, or may hold an inter-professional case review involving all participants in a particular case. The outcomes of such a review are focused on quality improvement and process development. Such reviews are insulated from the discipline process.

Information may also be gathered under the Quality of Care Information Protection Act (QCIPA) (QCIPA is designed to encourage health professionals to share information and hold open discussions to improve patient care without fear that the information will be used against them.) Information that is prepared by or for a Quality of Care Committee designated under the Act is shielded from disclosure in legal proceedings and from most other types of disclosures. Immunity protects the person disclosing the information. One cannot retaliate against the discloser; to do so is an offence.

Reference:

www.health.gov.on.ca/english/providers/legislation/priv_legislation/qcipa_webcast/qcipa_overview.ppt#289

Complaints:

The Chief of Staff may investigate complaints regarding alleged practice concerns and behaviours of professional staff. The results of such investigation will be discussed with the staff in question and an appropriate response to the complainant formulated.

Breach of hospital by laws, rules and regulations:

The Chief of Staff may respond to a professional staff member in breach of by laws, rules or regulations by the following procedures.

(a) Background

The members of the Professional Staff have responsibilities which extend beyond those directly related to patient care. Members are required to be in compliance with hospital policies and rules and regulations and By-laws.

Progressive discipline is a step wise process that can be used to work with members of the Privileged Staff who do not comply with expectations associated with membership.

In situations where immediate resolution to a complaint is not achieved it provides for a graded disciplinary response prior to taking action under the By-laws and Rules & Regulations to reduce or remove a member's privileges.

At the discretion of the Chief of Staff it will be determined whether the nature and severity of the individual incident, series of incidents, or consequences thereof, warrant certain steps in the progressive discipline policy to be omitted.

The member shall retain the right to appeal any decisions made under this policy to the Medical Advisory Committee with the assistance of a member or past member of the Professional Staff Association.

(b) Policy

Progressive discipline is a three step process for managing complaints that are of a serious or recurrent nature involving members of the Professional Staff where their performance falls below expected standards. It is to be applied when an immediate and satisfactory resolution of a complaint is not achieved as part of the normal complaints management process. During the complaint management process a complete investigation must be completed.

In some situations where the complaint is of such a serious nature that a higher step may be more appropriate, such decisions shall be made at the discretion of the Chief of Staff. At no time shall the application of the Progressive Discipline Policy prevent a complaint from being referred for immediate or mid-term action related to privileges as outlined in the By-laws.

Consequences as detailed in the Procedure as follows shall be applied as appropriate and may include but are not limited to the following:

Step 1: Written apology facilitated meeting, verbal reprimand.

Step 2: Remedial courses, written reprimand, facilitated meeting, and follow-up interview.

Step 3: Loss of access to elective resources, written reprimand, assessment by OMA Professional Staff Services, mandatory remedial courses.

At each of the three steps, the following principles will be followed:

- (i) The member will be provided with sufficient information in writing regarding the complaint in order to respond appropriately.
- (ii) The member will be given a reasonable opportunity to present relevant information on his/her behalf.
- (iii) The member will be informed of the expectations of the Hospital in the situation under review and specifically how the member's performance/behaviour does not meet the expectation.
- (iv) Discussion will occur regarding corrective action focusing on prevention of recurrent situations in the future.
- (v) Written follow up outlining the consequences of the members performance/behaviour will be provided and include consequences of any future incidents.
- (vi) The member may request representation by a member or past member of the Professional Staff Association or legal counsel at any of the meetings scheduled as part of this Policy.
- (vii) The member shall have the right to appeal any decision made under this policy to the Medical Advisory Committee.

(c) Procedure

Step 1

The Chief of Staff shall meet with the practitioner and provide information as required for the practitioner to respond appropriately. Oral and/or written communication of expectations will be provided to the practitioner. The practitioner will be expected to act in the future in a manner to avoid a recurrence of the behaviour(s) or action(s) leading to the complaint. A written apology will be required when appropriate. A verbal reprimand may

be given and the practitioner may be required to meet with the other parties involved. This meeting to be facilitated in a neutral environment with the aim of improving communication and reduction of the possibility of a recurrence. Notification of the complaint and outcome to be provided in writing to the Chief of Staff. The practitioner will be advised that failure to change his/her behaviour will result in progression to Step 2.

Step 2

This step applies when a practitioner is recurrently in violation of hospital policy or when the event is of such a serious nature that the options in Step 1 are inadequate. The Chief of Staff will meet with the practitioner to review the nature of the complaint. The practitioner will be provided a written summary of the complaint and will be given an opportunity to respond in writing.

Actions that may be taken include but, are not limited to the following:

- (f) It is expected that behaviour will change to avoid any further recurrences.
- (ii) A written apology where appropriate.
- (iii) Attendance at courses provided through the OMA or CPSO or on an individualized basis such as:
 - Anger Management
 - Communications
 - Documentation/Health Records
- (iv) Written reprimand to be filed on the practitioner's credentials file.
- (v) Notification that failure to change behaviour will lead to progression to Step 3.
- (vi) A follow-up interview in 3-6 months with the Chief of Staff.

Step 3

This step applies when a practitioner has recurrent behaviour and has already been through Steps 1 and/or 2, or when the complaint is of a serious nature requiring a greater level of intervention. The Chief of Staff will meet with the practitioner.

Actions that may be taken:

- (i) Loss of access to elective resources.

- (ii) Written reprimand with notification of MAC.
- (iii) Mandatory attendance at a course offered by the CPSO, OMA or other professional organization.
- (iv) Assessment by OMA Physician Services or other professional organization.

- (d) Referral of matter to the Medical Advisory Committee and review of privileges

Any matter of a serious or recurrent nature not effectively dealt with through the Progressive Discipline Policy may be referred to the Medical Advisory Committee under the provisions of the By-laws and Rules & Regulations for either immediate or mid-term action in regards to privileges. Any member who does not meet performance expectations following the application of Step 3 of this Policy shall similarly be referred to the Medical Advisory Committee for a review of privileges.

- (e) Appeal Process

At any of the steps:

- (i) If the member of the Professional Staff feels the progressive discipline process has been applied unjustly then an appeal may be made as per The Hospital bylaws
- (ii) The Professional Staff should be advised of resources available to assist in improving their performance and should meet with the President of the Professional Staff Association to discuss.

ARTICLE XVI. DISASTER EMERGENCY ASSIGNMENTS

Practitioners shall respond to a disaster code in accordance with the hospital's Emergency Preparedness & Procedures Policy.

ARTICLE XVII. MEDIA INQUIRIES AND DISSEMINATION OF INFORMATION

The Board Chair and the CEO are the official spokespersons for the Hospital.

Practitioners should be familiar with the following hospital policies that can be found in the Administrative Manual:

- Release of Information – Responsibility/Copy Production
- Release of Information – Authorization for the Release of Information Form

- Release of Information – Correspondence Fees
- Release of Information – Statements to Media and Patient Conditions
- Release of Information – Internal Authorized Access
- Release of Information – External Authorized Access
- Release of Information – Patient Access and Amendment to Health Records Policy
- Release of Information – Release of Autopsy – Death Certificates
- Request for Access to Health Record Form
- Request for Correction or Amendment to Personal Health Record
- Notification to Patient Forms
- Patient Declaration of Values

ARTICLE XVIII. AMENDMENTS

The Medical Advisory Committee, after the appropriate consultation with the Professional Staff, shall make recommendations to the Board on amendments to the Professional Staff rules as may be necessary.

APPENDIXES

APPENDIX (I) THE HOSPITAL PROFESSIONAL STAFF ASSOCIATION NOMINATION FORM

APPENDIX (II) THE HOSPITAL PROFESSIONAL STAFF ASSOCIATION PROXY VOTE FORM

APPENDIX (III) IMPACT ANALYSIS - NEW & EXPANDED

APPENDIX (IV) IMPACT ANALYSIS - REPLACEMENT OR ADDITION



GROVES MEMORIAL COMMUNITY HOSPITAL
North Wellington Health Care Corporation



Professional Staff Association Officers

NOMINATION ACCEPTANCE FORM

We, as Active Staff members of the (please check one):

Groves Memorial Community Hospital OR

North Wellington Health Care Corporation

Professional Staff hereby nominate:

Dr. _____ for the position of (President/Vice President/Secretary)

Print Name

Signature

Print Name

Signature

I, hereby accept the nomination for the position of _____.

(President/Vice President/Secretary)

Print Name

Signature



GROVES MEMORIAL COMMUNITY
HOSPITAL NORTH WELLINGTON HEALTH
CARE CORPORATION



PROXY FORM

The undersigned, being a holder of Active Staff Privileges at (please check one):

Groves Memorial Community Hospital OR

North Wellington Health Care Corporation

hereby appoints and authorizes Dr. _____

of the town of _____ to vote for him/her and on his/her behalf

at the Medical Staff Association meeting to be held on _____ in the month
of _____

in the year _____ and at any adjournment thereof.

(date)

(signature)

(print name)

APPENDIX III

PROFESSIONAL STAFF IMPACT ANALYSIS – NEW OR EXPANDED PROGRAM

PROFESSIONAL STAFF IMPACT ANALYSIS**Professional Staff Impact on Hospital Operations****New or Expanded Program**

To be completed by Chief of Staff and Manager of Program prior to implementing new program/ service/ procedure or recruitment of Professional Staff requiring additional resources, operating dollars or capital funding.

A. GENERAL INFORMATION

☐ New or Expanded Programs	
Program Description:	
Proposed Program Start Date	

B. FUNDING SOURCES

Source of funding: _____

C. NEW OR EXPANDED PROGRAMS

- Will this **NEW** or **EXPANDED** program provide services not currently available in the region?

☐ Yes	☐ No
------------------------------	-----------------------------

- Is this part of a REPLACEMENT Plan?

☐ Yes	☐ No
------------------------------	-----------------------------

- How will this new or expanded program improve health outcomes and benefit the department/organization?

- What would be the most obvious impact on client care and/or outcomes if this program were not available?

D. RESOURCES IMPACT

Estimate any increases in inpatient volume with respect to the proposed staff members' clinical practice.

Procedure/CMG	# Patients		Expected Length of Stay
	Year 1	Year 2	

Estimate the following outpatient volume with respect to the proposed staff members' clinical practice.

Procedure/CMG	# Patients	
	Year 1	Year 2

	Out-Patient Impact		
	High	Low	High
Laboratory			
Haematology			
Blood Bank			
Biochemistry			
Cytology			
Microbiology			
Pathology			
ECG			

	In-patient Impact			Out-Patient Impact		
	High	Low	No	High	Low	No
Diagnostic Imaging						
X-ray						
Ultrasound						
CT Scan						
Special Procedures						

	In-patient Impact			Out-Patient Impact		
	High	Low	No	High	Low	No
Pharmacy						
Oncology						
Antibiotic Utilization						
TPN						
Streptokinase or tPA						
Investigative Drugs						

	In-patient Impact			Out-Patient Impact		
	High	Low	No	High	Low	No
Ambulatory Care	N/A	N/A	N/A			
OBS Beds				N/A	N/A	N/A
Medical Beds				N/A	N/A	N/A
Surgical Beds				N/A	N/A	N/A
CCC Beds				N/A	N/A	N/A
Speech Therapy	N/A	N/A	N/A			
Diabetic Education	N/A	N/A	N/A			
Physiotherapy	N/A	N/A	N/A			
Respiratory Therapy	N/A	N/A	N/A			
Surgical Daycare	N/A	N/A	N/A			
	In-patient Impact			Out-Patient Impact		
	High	Low	No	High	Low	No
Health Records						
Psychosocial Support						
Other (specify)						

E. OTHER POTENTIAL AREAS IMPACTED

Support Services	High Impact	Low Impact	No Impact
Nutrition & Food Services			
Material Management			

MDRD			
Biomedical Engineering			
Maintenance			
Housekeeping			
Other (state)			

F. AMBULATORY CARE CLINIC ACTIVITY PROFILES (determined in collaboration with Clinical Manager)

- Does the applicant expect to operate a clinic?

☐ Yes 	☐ No	☐ Unknown
---	-----------------------------	----------------------------------

If **Yes**, is this:

☐	New clinic
☐	Existing clinic

- Will additional hours of clinic time be required?

☐ Yes 	☐ No	☐ Unknown
---	-----------------------------	----------------------------------

If **Yes**, quantify total number of additional hours/month:

☐ Hours/month _____

- Will additional staff be required?

☐ Yes 	☐ No	☐ Unknown
---	-----------------------------	----------------------------------

If **Yes**, quantify position, number of FTEs and cost of position(s):

- Will additional equipment/drugs/supplies be required?

☐ Yes 	☐ No	☐ Unknown
---	-----------------------------	----------------------------------

If **Yes**, please list anticipated needs and costs:

G. SPACE/OFFICE REQUIREMENTS

- Will examining or treatment space be required at the hospital?

☐ Yes	☐ No
↓	

If **Yes**, please explain (specify location if applicable):

- Will this appointment require additional dedicated in-patient beds?

If Yes , how many?	-
Where?	-

- Will an office in the organization be required?

☐ Yes	☐ No
↓	

If **Yes**, is existing space available within the department's present allocation?

☐ Yes	Location: _____
------------------------------	-----------------

- Indicate amount of space-required: _____ sq. ft.

Are renovations required?

☐ Yes	☐ No
↓	

If **Yes**:

Source of Funds: _____

Rent/sq. ft. to be paid: _____

- Identify office equipment and furnishings required as well as source of funds.

- Will integration to current information systems be required?

☐ Yes	☐ No
------------------------------	-----------------------------

H. FINANCIAL SUMMARY Sections H to J for CFO to complete

- Sources of Revenue Generation:**

Is there potential for revenue-generating activity through this appointment?

☐ Yes 	☐ No
---	-----------------------------

If **Yes**, please explain including dollar values if known.

- Net impact**

How will this impact be addressed in the Program's Operating Budget?

I. CAPITAL BUDGET (more than \$2,500)

- Equipment (including installation and start-up):

☐	Not Required
--------------------------	--------------

OR

Description of Equipment	Cost

- Construction and Renovations Costs:

☐	Not Required
--------------------------	--------------

OR

Work to be done	Cost

- Biomedical Engineering/Maintenance Costs:

☐	Not Required
--------------------------	--------------

OR

Engineering/Maintenance	Cost

J. OPERATIONAL BUDGET (estimates)

- Medical and Surgical Supplies: (Sutures, Dressing, Instruments, etc.)

Item	Cost	Year 1	Year 2	Year 3

- Drugs and IV:

Item	Cost	Year 1	Year 2	Year 3

- Minor Equipment (less than \$2,000):

Item	Cost	Year 1	Year 2	Year 3

- Additional FTEs Required:

☐ Yes 	☐ No
---	-----------------------------

If **Yes**, state classification of staff (e.g., RN):

Staff Classification	Year 1		Year 2		Year 3	
	FTE	Cost	FTE	Cost	FTE	Cost

I have reviewed the above report and, in my opinion, it presents fairly the impact of this change.

Signatures:

VP of Clinical Services

Date

Chief Financial Officer

Date

Chief of Staff

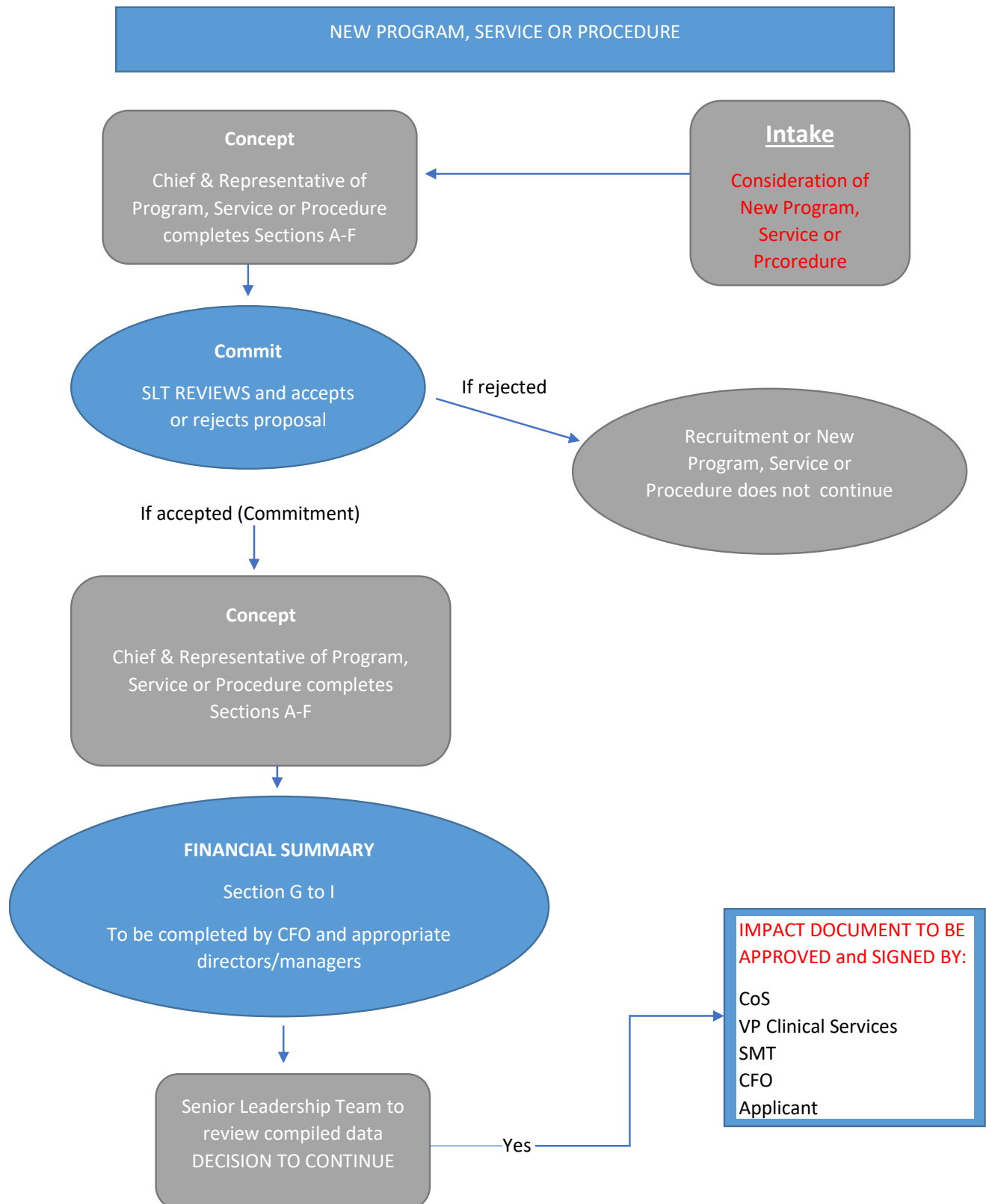
Date

President and CEO

Date

Final date of approval of new or expanded program: _____

PROFESSIONAL STAFF IMPACT ANALYSIS – NEW OR EXPANDED PROGRAM



APPENDIX IV

PROFESSIONAL STAFF IMPACT ANALYSIS - **REPLACEMENT** or **ADDITION****PROFESSIONAL STAFF IMPACT ANALYSIS****Professional Staff Impact on Hospital Operations**

To be completed by Chief of Staff and Manager of Program prior to recruitment of Professional Staff.

Sections A to F (pages 1-5) for Chief and Proposed Applicant (if identified) to complete

A. GENERAL INFORMATION

☐ New Professional Staff Member	
Name:	
Department:	
Main Specialty:	
Proposed date of appointment:	

B. APPOINTMENT

- Professional Staff category:

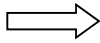
☐	Associate: Physicians, Dentists or Midwives who are applying for appointment to the Active Staff, subject otherwise to the determination of the Board, will be assigned to the Associate Staff. In no event shall an appointment to the Associate Staff extend beyond two (2) years.
☐	Consulting: Specialists with Fellowship of Certification in their speciality
☐	Courtesy: Physicians, Dentists, Midwives. Meets a specific service need or where the Board deems it advisable. Has limited privileges as granted by the Board on an individual basis. Attends patients and undertakes treatment and operative procedures only in accordance with the kind and degree of privileges granted by the Board.
☐	Locum Tenens Staff: Physicians, Dentists, Midwives. Specific clinical needs for a defined period of time as a planned replacement or to provide episodic or limited surgical consulting services. May be up to 1 year with 1 additional year of renewal (may be 2 years in exception circumstances).

C. PROFESSIONAL STAFF PLANNING

- Is this appointment according to the hospital's Board approved Professional Staff Human Resource Plan?

☐ Yes	☐ No
------------------------------	-----------------------------

- Position is:

☐	A NEW ADDITIONAL appointment to a Department
☐	A REPLACEMENT within a Department (<i>if applicable give name and date departure</i>): _____
☐	SUCCESSION PLANNING
☐	A NEW AND EXPANDED PROGRAM? ☐ NO ☐ YES  If YES, this analysis must be accompanied by the New or Expanded Program Document

- Is this position consistent with the Department's strategic direction?

Identify the needs to be met by this appointment (<i>i.e., Community and hospital benefits, goals and objectives, etc.</i>)?

- Is this position consistent with the hospital's Strategic Plan?

☐ Yes	☐ No
------------------------------	-----------------------------

- How does this appointment benefit the population served (with reference to the clinical outcomes, teaching, research or other activities?)

D. ESTIMATE PROFILE OF CLINICAL PRACTICE

- What is the clinician's approximate weekly time commitment to:

a) In-patient activities:

b) Ambulatory Care activities:

c) Emergency Department Commitment?

☐ Yes 	☐ No
---	-----------------------------

Comment:

d) Private Practice Commitment?

☐ Yes 	☐ No
---	-----------------------------

Comment:

- Will the new clinician be performing or developing any new program(s) or procedure(s) that are not currently performed at the hospital, in the first five years following appointment?

OR

- Will diagnostic and/or treatment procedures be ordered by the applicant that are not currently undertaken at Wellington Health Care Alliance?

☐ Yes to either 	☐ No
---	-----------------------------

If yes The “New or Expanded Program Document” must be completed

- Estimate the new Professional Staff applicant’s primary **IN-PATIENT** volumes:

- Estimate the new Professional Staff applicant’s **OUTPATIENT** volume (*day surgery cases included here*)

E. HOSPITAL STAFFING IMPACT

Indicate the impact the new position will have on the following staff:

Staffing	High Impact If high, please explain	Low Impact	No Impact
Other Professional Staff			
Nursing Staff			
Paramedical Staff			
Health Records			
Clerical Staff			
Other Support Staff			
Other (specify)			

F. UTILIZATION

- Any new procedures or request for equipment must go through the approval process, which includes:
 - o Discussion with the appropriate Clinical Service Team, Clinical Manager.
 - o The Chief of Staff will bring the form to the Medical Advisory Committee for discussion and recommendation.
 - o **All new equipment approval is required.**

Signed:

Chief of Staff _____

Proposed Applicant _____ (if applicable)

Date: _____

Sections G to K for Chief and Appropriate Program Manager to complete with input from CFO, VP Clinical Services

G. Resources Impact

	In-patient Impact			Out-Patient Impact		
	High	Low	No	High	Low	No
Laboratory						
Haematology						
Blood Bank						
Biochemistry						
Cytology						
Microbiology						
Pathology						
ECG						

	In-patient Impact			Out-Patient Impact		
	High	Low	No	High	Low	No
Diagnostic Imaging						
X-ray						
Ultrasound						
CT Scan						
Special Procedures						

	In-patient Impact			Out-Patient Impact		
	High	Low	No	High	Low	No
Pharmacy						
Oncology						
Antibiotic Utilization						
TPN						
Streptokinase or tPA						
Investigative Drugs						

	In-patient Impact			Out-Patient Impact		
	High	Low	No	High	Low	No
Ambulatory Care	N/A	N/A	N/A			
OBS Beds				N/A	N/A	N/A
Medical Beds				N/A	N/A	N/A
Surgical Beds				N/A	N/A	N/A
CCC Beds				N/A	N/A	N/A
Speech Therapy	N/A	N/A	N/A			
Diabetic Education	N/A	N/A	N/A			
Physiotherapy	N/A	N/A	N/A			
Respiratory Therapy	N/A	N/A	N/A			
Surgical Daycare	N/A	N/A	N/A			

	In-patient Impact			Out-Patient Impact		
	High	Low	No	High	Low	No
Health Records						
Psychosocial Support						
Other (specify)						

H. OTHER POTENTIAL AREAS IMPACTED

Support Services	High Impact	Low Impact	No Impact
Nutrition & Food Services			
Material Management			
MDRD			
Biomedical Engineering			
Maintenance			
Housekeeping			
Other (state)			
Office	High Impact	Low Impact	No Impact
Office Space on site			
Computer			
Office Equipment			
Administrative Support			

Health Records volume impact			
Other			

I. OPERATING ROOM

- Will Operating Room time be required?

☐ Yes 	☐ No
---	-----------------------------

If **Yes**, how many elective hours are requested?

☐ Hours/month _____

- Are the requested hours currently available within the Department's allocated Operating Room time?

☐ Yes	☐ No 
------------------------------	--

If **No**, will all operating room blocks need to be redistributed?

☐ Yes	☐ No
------------------------------	-----------------------------

- Will additional instrumentation be required?

If **Yes**, please list type of instrumentation.

J. AMBULATORY CARE CLINIC ACTIVITY PROFILES (determined in collaboration with Clinical Manager)

- Does the applicant expect to operate a clinic?

☐ Yes 	☐ No	☐ Unknown
---	-----------------------------	----------------------------------

If **Yes**, is this:

☐	New clinic
☐	Existing clinic

- Will additional hours of clinic time be required?

☐ Yes 	☐ No	☐ Unknown
---	-----------------------------	----------------------------------

If **Yes**, quantify total number of additional hours/month:

☐ Hours/month _____

- Will additional staff be required?

☐ Yes 	☐ No	☐ Unknown
---	-----------------------------	----------------------------------

If **Yes**, quantify position, number of FTEs and cost of position(s):

- Will additional equipment/drugs/supplies be required?

☐ Yes 	☐ No	☐ Unknown
---	-----------------------------	----------------------------------

If **Yes**, please list anticipated needs and costs:

K. SPACE/OFFICE REQUIREMENTS

- Will examining or treatment space be required at the hospital?

☐ Yes 	☐ No
---	-----------------------------

If **Yes**, please explain (specify location if applicable):

- Will this appointment require additional dedicated in-patient beds?

If Yes , how many?	-
Where?	-

- Will an office in the organization be required?

☐ Yes 	☐ No
---	-----------------------------

If **Yes**, is existing space available within the department's present allocation?

☐ Yes	Location: _____
------------------------------	-----------------

- Indicate amount of space-required: _____ sq. ft.

Are renovations required?

☐ Yes 	☐ No
---	-----------------------------

If **Yes**:

Source of Funds: _____

Rent/sq. ft. to be paid: _____

- Identify office equipment and furnishings required as well as source of funds.

- Will integration to current information systems be required?

☐ Yes	☐ No
------------------------------	-----------------------------

L. **FINANCIAL SUMMARY (with input from CFO)**

- Estimated Additional **Equipment** Expenditures (quantify \$):

- Estimated **Construction and Renovations** Required (quantify \$):

- Estimated Additional **Staffing** Requirements (quantify \$ and **FTEs**):

- Other **Additional Expenditures** (i.e., pharmaceutical/supplies/diagnostic testing):

- Sources of Revenue Generation:

Is there potential for WHCA revenue-generation through this appointment?

☐ Yes 	☐ No	☐ GMCH	☐ LMH	☐ PDH
---	-----------------------------	----------------------------------	---------------------------------	---------------------------------

If **Yes**, please explain including dollar values if known.

- **Net impact**

How will this impact be addressed in the Program's Operating Budget?

M. CAPITAL BUDGET (more than \$2,500)

- Equipment (including installation and start-up):

☐	Not Required
--------------------------	--------------

OR

Description of Equipment	Cost

- Construction and Renovations Costs:

☐	Not Required
--------------------------	--------------

OR

Work to be done	Cost

- Biomedical Engineering/Maintenance Costs:

☐	Not Required
--------------------------	--------------

OR

Maintenance	Cost

N. OPERATIONAL BUDGET (estimates)

- Medical and Surgical Supplies: (Sutures, Dressing, Instruments, etc.)

Item	Cost	Year 1	Year 2	Year 3
Sutures				
Dressings				

Drugs and IV:

Item	Cost	Year 1	Year 2	Year 3
I.V. with I.V. Catheter & Tubing				

- Minor Equipment (less than \$2,500):

Item	Cost	Year 1	Year 2	Year 3

- Additional FTEs Required:

☐ Yes	☐ No
	

If **Yes**, state classification of staff (e.g., RN):

Staff Classification	Year 1		Year 2		Year 3	
	FTE	Cost	FTE	Cost	FTE	Cost

I have reviewed the above report and, in my opinion, it presents fairly the impact of this position.

Signatures:

VP of Clinical Services

Date

Chief Financial Officer

Date

Chief of Staff/Chair of the MAC

Date

President and CEO

Date

Applicant (if applicable)

Date

Reviews:

Review by Credentials Committee

Date

Review by Medical Advisory Committee

Date

PROFESSIONAL STAFF IMPACT ANALYSIS – REPLACEMENT OR ADDITION

