Temiskaming Hospital / Hôpital Temiskaming

# Professional Staff Rules & Regulations

| | Approved By: |
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| | Medical Advisory Committee: March 9, 2023<br>Professional Staff: April 6, 2023<br>Board of Directors: May 30, 2023 |

# Temiskaming Hospital
# Professional Staff Rules & Regulations

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# PREAMBLE

The Professional Staff Rules and Regulations are meant to supplement the Board Appointed Professional Staff By-Law of Temiskaming Hospital. These Rules and Regulations shall become effective following their recommendation by the Medical Advisory Committee and approval by the Board in accordance with Article 2 of the Board Appointed Professional Staff By-Law.

These Rules and Regulations are made available, via the Hospitals website, to new Board Appointed Professional Staff members at the time of their initial appointment, and be reviewed as part of the annual reappointment process.

They shall remain in force until amended by the Medical Advisory Committee in accordance with the Professional Staff By-Law.

These Professional Staff Rules and Regulations will be reviewed annually.

# DEFINITIONS

In the Rules and Regulations, the following words and phrases shall have the following meanings:

**"Board"** means the Board of Directors of the Corporation

**"By-law"** means this Professional Staff By-law

**"Chief of Staff"** means the medical staff member appointed by the Board to serve as such in accordance with the Public Hospitals Act and this By-law

**"Most Responsible Provider"** (MRP) means a member of the Professional Staff with privileges who will have overall responsibility for the care of the patient

**"Patient"** means any in-patient or outpatient of the Corporation;

**"Professional Staff"** means the Physicians, Dentists, Midwives and Registered Nurses in the Extended Class, who are appointed by the Board and granted privileges to practice their profession in the Hospital;

# 1. PROFESSIONAL STAFF ASSOCIATION MEETINGS

## 1.1. Regular Meetings

The order of business shall be as follows:

a) Approval of the previous meeting minutes and any special meeting since the last regular meeting;
b) business arising from the minutes
c) report of the Medical Advisory Committee by Chief of Staff;
d) report of the President of the Professional Staff;
e) work plan
f) new business; and
g) adjournment.

## 1.2. Annual Meeting

The Annual Meeting will be held in April.

The order of business will be as follows:

a) minutes of the previous Annual Meeting;
b) business arising from the minutes;
c) report of the Medical Advisory Committee which shall include recommendations for the improvement of the professional work of the Hospital;
d) report of the President of the Professional Staff;
e) reports from any standing or special committees;
f) nominations for the Professional Staff elections;
g) election of officers for the following year; and
h) adjournment.

## 1.3. Special Meeting

The order of business will be as follows:

a) reading of the notice calling the meeting;
b) the business for which the meeting was called; and
c) adjournment.

## 1.4. Quorum

In any case where a quorum of the Professional Staff has not arrived at the place named for the meeting within thirty minutes after the time named for the start of the meeting, those members of the Professional Staff who have presented themselves shall be given credit for their attendance at the meeting for the purpose of satisfying the attendance requirement.

# 2. DOCUMENTATION

## 2.1. Outpatients

a) Patients referred to the Hospital for an outpatient service shall have had an appropriate requisition form clearly filled out by their care provider and submitted on their behalf to the appropriate outpatient department.

b) Outpatients referred to the Hospital for elective surgery in either the Emergency Room or the Operating Room, shall be booked in advance in accordance with established Hospital procedures.

## 2.2. Admissions

a) Only physicians and midwives who are members of the following categories may admit patients to the Hospital: Active, Associate, Locum Tenens and under certain circumstances, Courtesy Staff.

b) The admitting Professional Staff member shall be responsible for recording such information as may be necessary to ensure the protection of the patient from self-harm and the protection of other patients from any cause whatever such as mental health or infectious concerns.

c) No patient shall be admitted to Hospital until a provisional diagnosis has been recorded.

d) The Most Responsible Provider (MRP) is the practitioner most responsible for the in-hospital care of a particular patient. The MRP is responsible for writing and clarifying orders, and providing a plan of care, obtaining consultations as appropriate, coordinating care, as well as the discharge process.

   If the Emergency Physician deems admission of a patient appropriate, it is at the discretion of the Emergency Physician to continue to follow these admitted patients until 0800 hours, or they may contact the MRP at the time of admission to transfer care.

e) All patients being admitted for elective surgery shall be admitted one to two hours prior to the procedure, unless medical condition warrants earlier admission.

f) Patients for same day surgery procedures shall register at least one hour prior to the scheduled procedure.

g) Alternate Level of Care (ALC) designation will require completion of the ALC Order Set.

h) Unit designation is as per admission order set. Bed allocation remains the responsibility of the hospital.

i) All patients to be admitted as a direct admit require consultation with the department and completed admission order set prior to patient arrival.

## 2.3. Patient Care Responsibilities

a) Inpatients
   i. The attending Professional Staff member is responsible for the patient's care unless they specifically delegate the care to another Professional Staff member. When the MRP relinquishes the care of a patient to another physician, it is incumbent on the MRP to take reasonable steps regarding the patient's continued care until the new treating physician can assume care for the patient. The MRP might also be expected to coordinate the care of a patient receiving concurrent treatment from different physicians, including for example, arranging other consults. The MRP and the consultant should clarify their respective roles in ordering investigations and treatments and providing follow-up care. The information should be clearly documented in the medical record. The MRP should be contacted by the nurse-in-charge if any problems arise.
   ii. Notwithstanding paragraph (i), if an urgent problem arises with an inpatient and the attending physician cannot be reached, the nurse should contact the physician on-call for the Emergency Department and follow their instructions until the attending physician can be contacted.

b) Outpatients
   With the exception of the emergency department, appointments are the responsibility of the MRP.

## 2.4. Transfer of Responsibility

a) A Professional Staff member who has assumed responsibility for an inpatient's care shall remain responsible for that patient until the inpatient's discharge from Hospital or until the care of the inpatient is transferred to another Professional Staff member.

b) Pursuant to the Public Hospitals Act, where the Chief of Staff or Chief of Service has cause to take over the care of a patient, they shall do so, and they shall notify the President and Chief Executive Officer, the attending physician and the patient (or the patient's substitute decision-maker) as soon as possible.

c) Transfer of care for acute care, from one care provider to another (the "Accepting Professional Staff Member") must be done as an order and clearly indicated on the order sheet of the inpatient's record of personal health information. The Professional Staff member must confirm in the record of personal health information that:
   i. the Accepting Professional Staff Member has directly confirmed to the Professional Staff member that the Accepting Professional Staff member has accepted the transfer;

ii. the dates and time the accepting Professional Staff Member will be covering and when care is transferred back to the professional staff member;
iii. they have communicated the inpatient's vital information to the Accepting Professional Staff member; and
iv. When primary care is transferred, permanently or temporarily, from the Midwife to a physician, the physician, together with the patient, assumes full responsibility for subsequent decision-making. The midwife may provide supportive care within their scope of practice, in collaboration with the physician and the patient.

d) For effective internal communications, physicians must complete form D081 Physician Away and Sign Out Form and hand it to Reception. Per procedure ADM-MED-0001 Physician Away and Sign Out. In the case of physicians participating in a Hospitalist model, refer to schedule posted in PetalMD.

**2.5. Discharges**

Whenever possible, patients shall be discharged by 1000 hours. Where a discharge is pending, notification of the Nursing Staff the day prior to discharge is advisable. Every effort should be made to have the patient discharged on the date set out in the order. In extenuating circumstances, a patient may remain in the Hospital up to 24 hours after the date set out in the discharge order.

a) For all SCU designations, a daily reassessment will be completed. When the patient is discharged from the SCU/down graded, an order must be completed in the patients' medical record.

**2.6. Long-Stay Cases**

Physicians shall complete reports on patients that exceed estimated length of stay, as required.

**2.7. Dental Cases**

If a dental patient is to be admitted, the dentist will consult with the family physicians or town call physician.

**2.8. Order Sets**

All order sets shall be approved by the Pharmacy and Therapeutics Committee, Patient Order Set Committee and Medical Advisory Committee. A copy of these order sets shall be inserted in the patient's chart, authenticated by the Professional Staff member.

**2.9. Health Records**

a) The attending Professional Staff member shall be responsible for the preparation of a complete health record for each patient.

b) Reports will be deemed authenticated if one of the following conditions is present:
i. an original signature;

ii. the following authentication statement on dictated reports – "Authenticated by Dr. -----';
iii. a signature stamp which meets approved guidelines;
iv. identifiable initials.

c) A complete health record must be maintained for all Hospital patients as outlined in the *Public Hospitals Act*, the *Medicine Act*, College of Physicians and Surgeons of Ontario and the Professional Staff By-law, policies and procedures.

d) The medical record for a patient, other than an out-patient, shall include:
   i. A history of the patient
   ii. All provisional and final diagnoses with respect to the patient
   iii. All orders for treatment or investigation with respect to the patient in the hospital
   iv. Progress notes with respect to the patient
   v. Discharge summaries
   vi. Within twenty-four hours of admission, an admitting note by the MRP, unless already completed by the Emergency physician, shall be entered in the medical record of the patient to clearly set out the reason for admission.
   vii. A complete medical history and physical examination, including provisional diagnosis, shall be recorded by the MRP for all patients within seventy-two hours of admission.
   viii. A preadmission history and physical examination is accepted as part of the medical record and must be dated within one month of the admission date.
   ix. An annual physical examination shall be recorded by the family physician for all long-term care patients.
   x. Every patient encounter and all patient-related information must be legibly documented and dated in the medical record. Each record of a patient encounter, regardless of where the patient is seen, must include a focused relevant history, documentation of an assessment and an appropriate focused physical exam (when indicated), including a provisional diagnosis (where indicated), and a management plan.

e) Progress notes are required when there has been any changes in the patient's condition or management plan and:
   i. Daily progress notes on SCU and active acute care patients.
   ii. Weekly progress notes for ALC Rehabilitation patients.
   iii. ALC Community, ALC Nursing Home and Complex Continuing Care patients require progress notes at least every thirty days.

f) The discharging provider shall provide and sign a discharge summary for all inpatients and dated and signed by the attending provider. All discharge summaries must include:
   - identifying information (e.g., author's name and status, name of the MRP, patient's name, health record number, admission date, and discharge date);

- distribution of copies to the referring provider and/or family physician;
- a brief summary of the management of each of the active medical problems during the admission, including major investigations, treatments, and outcomes;
- details of discharge medications, including reasons for giving or altering medications, frequency, dosage, and proposed length of treatment;
- follow-up instructions and specific plans after discharge, including a list of follow-up appointments with consultants, further outpatient investigations, and outstanding; and
- tests and reports needing follow-up.

g) The content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. A final diagnosis compatible with clinical and pathological findings shall be recorded.

h) Professional Staff shall fully comply with the facility-wide policy PHA-20 Medication Related Abbreviations.

i) Electronic Authentication of Dictated Documents.
   i. All dictated reports may be electronically authenticated.
   ii. Use of electronic authentication is voluntary on the part of the Professional Staff member.
   iii. Choosing to not subscribe to electronic authentication, all appropriate entries on the medical record must be signed.
   iv. If electronic authentication will be used:
      - A unique access code will be assigned and will be maintained by the Health Records Department.
      - An authentication agreement will be signed and kept in the Professional Staff members' Credentials file in Administration.

j) The Health Records Department will make reasonable efforts to facilitate the chart completion process. In the event there is outstanding documentation, the record shall be assigned to the applicable Professional Staff member for completion. This includes ensuring that incomplete records are available for the Professional Staff members' completion as soon as possible post discharge and the individuals are notified of incomplete records in a timely manner. Health Records shall, at a minimum, check for completion of:
   i. History and Physical;
   ii. Operative Report; and
   iii. Discharge Summary.

k) Health Records will count all incomplete medical records every second Wednesday of every month. Each Professional Staff member will be notified of the number of incomplete charts that can be found in their box.

   Professional Staff members are required to complete all incomplete records within 14 days of the health record being made available to complete. Charts that are to be completed but are not currently in the Professional Staff members box for completion will not be counted against them.

Bi-monthly notification shall be sent to all Professional Staff members with outstanding records (Regular monthly chart count).

Two weeks after monthly chart count, a second notification shall be sent to the Professional Staff member advising that if the outstanding records are not completed within 72 hours, the matter will be forwarded to the Chief of Service, Chief of Staff or most appropriate clinical leader for appropriate action.

As per the Professional Staff By-law Article 4.3 Immediate Action, the Chief Executive Officer, or Chief of Staff, or Chief of Service may temporarily restrict privileges, if appropriate.

l) Medical records are the property of the Hospital and shall not be removed without the written consent of the President and Chief Executive Officer.

m) The health record may be held on the Nursing Unit, as per procedure HER-GEN-0036 Unreturned Patient Charts, Retrieval of.

n) No health record shall be filed until it has been completed and duly signed, except on the recommendation of the Quality of Care/Medical Audit, Tissue and Transfusion Committee (QCC).

o) Any dictations made by a medical student must be signed off by the supervisory physician.

p) Medical Residents will electronically authenticate their own dictations and an electronic signature of the respective liaison physician will also be indicated.

q) Active physician members of the QCC will conduct chart peer reviews.

r) The Chair of QCC will inform the Professional Staff member of their chart peer review results.

s) If improvement is required, a follow up review will occur in two(s) months.

t) If improvement is not noted at this time, the Chief of Staff will be notified.

## 2.10. Consent to Treatment

When obtaining consent for procedures / treatments, informed consent will be document on form ‘P303 Consent to Treatment’ in compliance with policy ADM-G-43 Consents.

# 3. CLINICAL RULES

## 3.1. Consultations

When the MRP asks for a consultation: consultation shall mean opinion only unless the MRP notes on the medical record of the patient that the consultation is for shared care or total transfer of care. Consultations will occur directly between MRP to consulted physician.

Consultations will occur at the discretion of the MRP as guided by their governing body, clinical competence, clinical presentation and hospital resources.

a) Obstetrical
   i. delivery less than 37 weeks gestation unless labour is spontaneous and otherwise uncomplicated. For further detail, refer to policy ADM-M-87 Maternal and Newborn Levels of Care.
   ii. in induction/augmentation cases as outlined in policy ADM-M-91 Induction of Labour.
   iii. on any infant in respiratory distress and any infant whose condition gives cause for concern to the physician or midwife;
   iv. in cases of multiple births;
   v. Trial of Labour After Caesarean (TOLAC); and
   vi. in cases where there may be an increased risk to the mother and the fetus. Such conditions should include:
      - gestational hypertension with complications;
      - third trimester hemorrhage;
      - severe postpartum hemorrhage;
      - prolapse of the umbilical cord; and
      - any serious medical complications.

## 3.2. Surgery

OR Bookings will be completed as per procedure 'AMB-GEN-0021 OR Guidelines and Particulars'.

a) The surgeon shall check the patient's identification and chart to ensure the procedure is being done on the correct patient, side, limb, etc.

b) The surgical team shall be in the OR and ready to begin surgery at the scheduled time or the case may be rescheduled to a later time at the discretion of the Operating Room Team Leader or delegate.

c) Sponge and instrument counts shall be carried out in all cases where required, as outlined in the Operating Room procedure manual.

d) All equipment related tissue/organ perforations or burns must be reported in rL solutions and Disclosure of Adverse Critical Events must be followed.

e) Every patient undergoing surgery shall have an operative report completed by the surgeon on the same day as the operation.

f) The surgeon has the prime responsibility to write post-op orders.

g) The surgeon may choose to have another physician write orders. In this case it will be indicated on the Provider's Order Form who is to write orders and under what circumstances.

h) In the situation where the anaesthetist writes post-op orders, these will be followed for up to 24 hours.

i) An assistant is required in all cases of major surgery and assigned at the time of booking.

### 3.3. Anaesthesia

a) Anaesthetic privileges will only be granted to those who have a minimum of six months' postgraduate training in anaesthesia or equivalent.

b) Anaesthesia must be carried out in accordance with the approved procedures for the Anaesthesia service.

c) The presence of the anaesthetist is required for the insertion of the epidural and all bolus or top-up doses of anaesthetic solution. Any changes in the epidural infusion must be initiated by the anaesthetist. They will be readily available by phone to deal with any problems or side effects as specified in the order sets.

d) A Pre-Anesthetic Assessment is to be documented by the Anaesthesiologist for all patients undergoing a regional anaesthetic, a general anaesthetic or a sedation monitored patient.

### 3.4. Drugs and Orders

a) Drugs accepted for regular use in the Hospital shall be those listed in the Hospital Formulary. The members of the Professional Staff shall acquaint themselves with and adhere to the rules regarding drug administration as stated in the Hospital's Formulary.

b) New drugs to be added must be approved by the Pharmacy and Therapeutics Committee.

c) The pharmacist may substitute the generic equivalent unless otherwise directed by the Professional Staff member.

d) Dangerous drugs, as determined by the Pharmacy and Therapeutics Committee, should be ordered for a specific number of doses or duration. Details shall be outlined in policy form.

e) Verbal Professional Staff Orders:
Any of the following in the employ of the Hospital may transcribe an authorized (professional staff with admitting privileges or any Medical Resident working under the supervision of a professional staff member with admitting privileges) prescriber's verbal order:

- Registered Nurse, Registered Practical Nurse;
- Registered Pharmacist for medication related orders;
- Registered Respiratory Technician for respiratory therapy related orders;
- Registered Dietician for nutrition related orders; and
- Midwife.

Verbal orders are accepted only in the emergency situation or where the prescriber cannot document their orders. In all other situations, the prescriber will write their own orders.

Verbal orders cannot be accepted for chemotherapeutic agents (cytotoxic), oral or injectable, including chemotherapeutic agents used for non-oncologic indications.

All verbal orders will be co-signed by the prescriber immediately following an emergency or on the first visit to the hospital in non-emergency situations.

### 3.5. Obstetrics

Refer to ADM-M-87 Maternal and Newborn Levels of Care policy.

a) A complete prenatal report shall become part of the patient's medical record at the time of admission.

b) For the induction or augmentation of labour, using vaginal prostaglandin or oxytocin, the Professional Staff member should be immediately available by telephone and within twenty minutes of personal attention.

c) Inductions will not be done, for any reason, when there is no caesarean-section coverage.

d) Consideration for a second NRP –qualified attendant should be given in the following scenarios:

- Meconium stained fluid
- Deliveries < 37 weeks
- Vacuum assisted delivery (consider double setup in OR if appropriate)
- Confirmed or suspected macrosomia / Anticipated shoulder dystocia
- Evidence of fetal compromise with anticipated need for resuscitation at birth
- Twin delivery
- SSRI/SNRI use in pregnancy – Anticipated neonatal maladaptation

- Consider if history of severe Post-Partum Hemorrhage (PPH) or anticipated PPH

e) All scheduled elective c-sections will have a Neonatal Resuscitation Program (NRP) certified physician present at delivery to attend to the newborn. In addition, a NRP certified Midwife will also be present at delivery to attend to the newborn in cases where the delivery is a Midwifery patient. For all other scheduled elective cases, a NRP certified Respiratory Therapist will be present. Therefore the following will always be booked and present at scheduled elective c-section deliveries:
    - Surgeon
    - Surgical Assist (physician)
    - Baby Doctor (NRP certified OB physician)
    - Midwife or Registered Respiratory Therapist (NRP certified)

# 4. GENERAL

## 4.1. Continuing Medical Education

a) All members of the Active Professional Staff are required to have a minimum of 25 hours of formal continuing education per year prior to renewal of their privileges.

b) The 25 hours of formal education shall follow the guidelines set by either the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada for education credits. Credits may be obtained through attending courses; time spent upgrading clinical skills with clinicians; local clinic days with visiting specialists giving lectures; telemedicine, televideo-conferencing, Journal Club or Grand Rounds.

c) Obstetric - Practitioners who provide obstetrical service are required to attend within the suggested timeframe: the Neonatal Resuscitation Program (NRP) programs every two years; and one of the following at minimum - Advanced Life Support in Obstetrics (ALSO) course every five years; Advances in Labour and Risk Management (ALARM) course every five years; MORE$^{OB}$ program every 2 years; Emergency Skills Workshop (ESW) every 2 years; Fetal Heart Surveillance is required for all Active Staff obstetrical providers within the suggested timeframe of every 2 years.

d) Emergency Department – Physicians are required to attend within the suggested timeframe: Advanced Cardiovascular Life Support (ACLS) course every two years; and it is strongly recommended to attend Paediatric Advanced Life Support (PALS) courses every two years, Advanced Trauma Life Support (ATLS) course every four years and ultrasound training every four years.

e) Nursing Administration will be responsible for organizing approved courses which include Advanced Cardiovascular Life Support (ACLS), Advanced Trauma Life Support (ATLS), Paediatric Advanced Life Support (PALS) and Neonatal Resuscitation Program (NRP). The cost of the Professional Staff courses will be the responsibility of the Professional Staff member.

## 4.2. Duty Rosters

Each member of the Active and Associate Professional Staff shall participate in the Town Call System unless excused by the Medical Advisory Committee for reasons acceptable to them {Professional Staff By-Law – 6.2 (2) e) and 6.3 (2) d)}.

Duty rosters for the Emergency Department, Anaesthesia Staff, Town Call and Obstetrics Coverage shall be organized by a designated member of the Professional Staff.

Physicians who are absent or unavailable for scheduled Emergency Room "On Call" responsibilities or fail to provide a replacement are in violation of established policy and as such will be reported to the President and Chief Executive Officer and the Chief of Staff. The physician will meet with the President and Chief Executive Officer within three (3) working days to discuss this.

### 4.3. Orientation

All Associate Staff members of the Professional Staff should undergo an orientation within three weeks of appointment. This would include a general orientation to the facility and a more detailed one to each service. The Chief of Staff will coordinate the orientation through Administration.

### 4.4. Quality Assurance

The medical quality assurance program shall include activities related to the entire Professional Staff. The audits and reports of the Professional Staff will be reported monthly to the Medical Advisory Committee and submitted to the Board of Directors. The Medical Advisory Committee will be responsible for monitoring the quality assurance activities of the Professional Staff.