



**LONDON HEALTH SCIENCES CENTRE**

**ST. JOSEPH'S HEALTH CARE, LONDON**

**PROFESSIONAL STAFF RULES AND REGULATIONS**

**[Approved by the Joint Medical Advisory Committee June 2007 and September 2007]**

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## **DEFINITIONS**

### **I. Definitions**

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

- i) "Accreditation" means the status of accreditation evidenced by the certificate of the Accreditation Canada ;
- ii) "Act" means the *Corporations Act* (Ontario), and where the context requires, includes the Regulations made under it;
- iii) "Administrator" means Chief Executive Officer as defined in section 1 of the Public Hospitals Act, the Chief Executive Officer of the Corporation;
- iv) "Board" means the Board of Directors of the Corporation;
- v) "By-Law" means any By-Law of the Corporation including the Professional Staff Bylaws from time to time in effect;
- vi) "Candidate Review" means a study conducted by the Chief Executive Officer, or designate, in consultation with the Integrated VP Medical Affairs, the Chair of MAC Chiefs of Department and Senior Medical Directors to determine the impact upon the resources of the Corporation of the proposed or continued appointment of any person to the Professional Staff;
- vii) "Chair" means Chair of the Medical Advisory Committee appointed by the Board;
- viii) "Chief Executive Officer" means, in addition to 'administrator' as defined in section 1 of the *Public Hospitals Act*, the Chief Executive Officer of the Corporation;
- ix) "Chief Operating Officer" means the senior employee responsible to the Chief Executive Officer;
- x) "Chief of a Department" means a member of the Professional Staff appointed by the Board to be responsible for the professional standards and quality of medical care rendered by the members of that Department at the Hospital;
- xi) "Chief of Service" means the Physician, Dentist or Midwife appointed by the Chief of a Department to be in charge of one of an organized service of a Department;
- xii) "College" means, as the case may be, the College of Physicians and Surgeons of Ontario, the Royal College of Dental Surgeons of Ontario, the College of Midwives of Ontario, or the College of Nurses of Ontario;

- xiii) "Consultant" means a physician/midwife/dentist who is qualified by both experience and training in a particular area to give an opinion on the condition in question.
- xiv) "Corporation" means London Health Sciences Centre with the Head Office at 800 Commissioners Road East, London, Ontario, N6A 4G5 until the Head Office is determined otherwise by the Board; or St. Joseph's Health Care with Head Office at 268 Grosvenor Street, London Ontario, N6A 4V2 until determined otherwise by the Board;
- xv) "Dental Staff" means the collection of legally qualified Dentists appointed by the Board to attend or perform dental services for patients in the Hospital;
- xvi) "Dentist" means a dental practitioner in good standing with the Royal College of Dental Surgeons of Ontario;
- xvii) "Department" means an organizational unit of the Professional Staff to which members with a similar field of practice have been assigned;
- xviii) "Extended Class Nursing Staff" RN(EC) means those Registered Nurses in the Extended Class in the Hospital,
  - 1. who are employed by the Hospital and are authorized to diagnose, prescribe for or treat out-patients in the Hospital, and
  - 2. who are not employed by the Hospital and to whom the Board has granted privileges to diagnose, prescribe for or treat out-patients in the Hospital;
- xix) "Hospital" means London Health Sciences Centre, including the Children's Hospital; or means collectively or individually, St. Joseph's Health Care London, and/or St. Joseph's Hospital and/or Parkwood Hospital (including the Western Counties Wing) and/or Regional Mental Health Care, London and/or Regional Mental Health Care, St. Thomas and/or Mount Hope Centre for Long Term Care;
- xx) "London's hospitals" means both the London Health Sciences Centre and St. Joseph's Health Care London;
- xxi) "Professional Staff Human Resources Plan" means the plan developed by the Chief Executive Officer in consultation with the Integrated VP Medical Affairs, the Chair of MAC, Chiefs of Department, and Senior Medical Leaders based on the mission and strategic plan of the Corporation and on the needs of the community, which plan provides information and future projections of this information with respect to the management and appointment of Physicians, Dentists, Midwives, and Extended Class Nurses who are or may become members of the Professional Staff;
- xxii) "Medical Advisory Committee" means the body who makes recommendations to the Board concerning Professional Staff matters, including but not limited to facilitating the development and maintenance of Rules

and Regulations, Policies, ethical guidelines and procedures of the Professional Staff; approving the departmental clinical and academic responsibilities of the Professional Staff; assisting and advising the Board and the Chief Executive Officer in carrying out the requirements of the University Affiliation Agreement as they apply to the Professional Staff;

- xxiii) "Medical Staff" means those Physicians who are appointed by the Board and who are granted privileges to practise medicine in the Hospital;
- xxiv) "Member" means a Member of the Corporation;
- xxv) "Midwife" means a Midwife in good standing with the College of Midwives of Ontario;
- xxvi) "Midwifery Staff" means those Midwives who are appointed by the Board and who are granted privileges to practise midwifery in the Hospital;
- xxvii) "Most Responsible Professional (? Provider or Person?) " (MRP) means a member of the Professional Staff with privileges who will have overall responsibility for the care of the patient;
- xxviii) "Patient" means, unless otherwise specified, any "in-patient" or "out-patient" of the Corporation;
- xxix) "Physician" means a medical practitioner in good standing with the College of Physicians and Surgeons of Ontario;
- xxx) "Policies" means the Board, administrative, and clinical policies of the Corporation;
- xxxi) "Privileges" or "privileges" means the rights and entitlements associated with the Professional Staff categories as provided for therein;
- xxxii) "Professional Staff" means those physicians, dentists, midwives and extended class nurses who are appointed by the Board and who are granted specific privileges to practise medicine, dentistry, midwifery;
- xxxiii) "Professional Staff Appointment" means the appointment or assignment of a Professional Staff member to a Department or Service in the Hospital, by the Board, within the categorization of Active, Modified Active, Term, Locum Tenens, Supportive, Honorary, Temporary, and Clinical Fellow;
- xxxiv) "Professional Staff Organization" includes the Medical, Dental and Midwifery Staff as contemplated by the Public Hospitals Act;
- xxxv) "Program" means a cluster of patient-centred services which optimizes patient care, education and research;
- xxxvi) "Public Hospitals Act" means the *Public Hospitals Act* (Ontario), and, where the context requires, includes the Regulations made under it;

- xxxvii) "Registered Nurse in the Extended Class" or RN (EC) means a member of the College of Nurses of Ontario who is a registered nurse and who holds an extended certificate of registration under the Nursing Act, 1991;
- xxxviii) "Research Institute" means the Lawson Health Research Institute;
- xxxix) "Rules and Regulations" means the Rules and Regulations governing the practice of the Professional Staff in the Hospital both generally and within a particular Department, which have been established respectively by the staff in general and the staff of the Department;
- xl) "Senior Medical Director" means a member of the Professional Staff employed by the Corporation who shall work collaboratively with the Vice President of Clinical Services and is accountable to the Chief Operating Officer;
- xli) "Service" means an organizational unit of a Department which is based on a sub-speciality area of clinical practice;
- xlii) "University" means The University of Western Ontario, London, Ontario, Canada;
- xliii) "Vice President, Medical" means the Vice President of the Corporation whose portfolio includes Medical Affairs

**A. GENERAL PURPOSE**

**I. Establishment of Rules**

- a) The Medical Advisory Committee, from time to time, and where appropriate, a Department or Service of the Professional Staff with the approval of the Medical Advisory Committee, may develop and implement policies, procedures and guidelines as it deems necessary to support the professional work provided by the Professional Staff. Such rules and regulations will be established to ensure that the conduct of the members of the Professional Staff is consistent with:
  - (i) the mission, vision and values of London Health Sciences Centre ([LHSC Mission Statement](#)) and St. Joseph's Health Care, London ([SJHC Mission Statement](#))
  - (ii) the Public Hospitals Act ([Public Hospitals Act](#))
  - (iii) and the Professional Staff By-Laws for ([SJHC Professional Staff By-laws](#)) and ([LHSC Professional Staff By-Laws](#))

**II. Interpretation**

- a) The rules of LHSC & SJHC provide guidelines for the rights, privileges and responsibilities of a member of the Professional Staff. They provide the framework for the function of the Professional Staff as individuals and members of departments. They provide a structure whereby members of the Professional Staff participate in the hospital's planning, policy setting and decision-making;
- b) The following rules and regulations are supplementary and additional to the regulations of the Public Hospitals Act and are to be observed and complied with by all members of the Professional Staff subject as aforesaid;
- c) Rules are subordinate to the Hospital By-Laws;
- d) Rules shall not repeat by-laws or statutory provisions;
- e) Rules must be clearly written and specific to the needs and circumstances of the Professional Staff member.

**III. Authority To Make Rules**

- a) The Medical Advisory Committee shall communicate such rules as may be necessary for the proper conduct of its work and to ensure a high quality of medical care for all LHSC & SJHC patients.
- b) The rules may be made, amended, or repealed at any regular meeting of the Medical Advisory Committee or at a special meeting called specifically for that purpose.
- c) Adoption, amendment, or deletion of Rules and Regulations shall require a two-thirds majority of those present and entitled to vote.
- d) Such changes shall become effective when approved by the Medical Advisory Committee.

#### **IV. General Statements of Compliance**

##### **GOVERNANCE**

- a) In addition to the Rules and Regulations, all members of the Professional Staff shall be familiar with and comply with the provisions of:
  - (i) the Public Hospitals Act ([Public Hospitals Act](#)) and the regulations there under respecting admission of patients to LHSC & SJHC;
  - (ii) the Professional Staff By-laws for LHSC & SJHC;
  - (iii) The University of Western Ontario Affiliation Agreement, [SJHC/UWO Affiliation Agreement](#) and [LHSC/UWO Affiliation Agreement](#), where applicable, and;
  - (iv) all other policies, including ethical guidelines of LHSC & SJHC.

##### **PROVISION OF CARE**

- a) All departments will ensure, through the Department Chief, that when clinical care or treatment is required for patients who present themselves to LHSC & SJHC that such care is available and is delivered in accordance with established professional standards and accepted clinical practice protocols.
- b) Refusal to deliver care to patients who present themselves to LHSC & SJHC must only be based on clinical grounds.
- c) Ambulatory, one day care or in-patients whose primary residence is outside of Canada seeking or being provided treatment at LHSC or SJHC, will be required to review and sign an Area of Jurisdiction Agreement. (Refer to the [LHSC Area of Jurisdiction Policy](#) or [SJHC Area of Jurisdiction Policy](#)), at the time of registering at the hospital. Signing this agreement, the patient agrees that the relationship between himself and LHSC & SJHC, its employees, directors, agents, principles, officers and trustees, as well as independent medical/dental/midwifery practitioners working at LHSC & SJHC and including all students participating in clinical experience at LHSC & SJHC related to their professional studies, will be governed by, and construed in accordance with the laws of the Province of Ontario.

#### **B. PATIENT CARE RESPONSIBILITIES**

##### **I. Most Responsible Professional (MRP)- Physician/Dentist/Midwife/RN(EC)**

- a) For inpatients, the admitting Professional Staff member is the MRP until discharge or until the care of the patient is transferred to another Professional Staff member (both an order to transfer and an acceptance will be noted in the health record). The MRP duties are as outlined below in addition to duties outlined in other sections of these Rules and Regulations and the Professional Staff By-Laws.

- b) The MRP (or his/her delegate) is responsible for:
- ensuring an admission note and orders are on the chart and authenticated within 24 hours and in advance of any operative procedure or other intervention. An admission note in acute care includes documentation of a history and a physical examination.
  - all care of the patient during their hospital stay unless some aspect of the patient's care is clearly the accountability of a consultant involved in their follow-up or concurrent care;
  - ensuring the health record is completed within 14 days of discharge. A completed health record is defined by the City Wide Health Records Committee;
  - ensuring there is continuous coverage for the patient's care when the MRP is unavailable;
  - arranging for the transfer of the care of the patient to another MRP if for any reason he/she is unable to perform his/her professional duties.
  - informing the appropriate hospital authority about any patient who may be a source of danger to himself or others. (e.g. infectious disease, emotional disturbance).

**Notes:**

- 1) In the Post Anesthetic Care Unit, the anesthesiologist is the MRP.
- 2) During a procedure, the Professional Staff member performing the procedure is the MRP until that procedure is completed.

- c) In accordance with the Professional Staff Bylaws, if a member of the Professional Staff unable to perform his/her duties in the hospital, he/she shall notify the Chief of the Department who shall arrange for another member of the Professional Staff to perform the duties and notify the Vice President Medical, and Chair of the Medical Advisory Committee.

## **II. General Admissions**

- b) Every patient admitted to LHSC or SJHC shall be thereafter continuously in the care of a member of the Professional Staff who shall be responsible for the overall care and treatment of the patient, such member being designated in these rules as the MRP;
- c) Any patient requiring admission to LHSC & SJHC for dental treatment by a Dentist must be co-admitted with the appropriate medical service with the member of the dental department as the primary MRP. Those cases that potentially require urgent airway management will be co-admitted with the Department of Otolaryngology. This requirement does not apply to Oral Maxillofacial Surgeons.
- d) A provisional diagnosis shall be given by the MRP (or delegate) before any patient is admitted.
- e) The condition of a patient shall be described as:
- a. EMERGENT when it appears to the MRP that any delay in admission will endanger the life, cause serious disability, or will result in continuance of severe pain;

- b. URGENT when it appears that any prolonged delay in admission will endanger the life or if not treated without unreasonable delay will become an emergent condition; and
  - c. ELECTIVE if not described as urgent or emergent.
- a) Physicians admitting emergent cases shall be prepared, if asked, to justify to the Medical Advisory Committee and the President and CEO of LHSC & SJHC or delegate, that the emergency admission was a bona fide emergency. The history and physical examination must justify the patient being admitted on an emergent basis.

Note: All patients receiving LHSC & SJHC clinical or diagnostic service on an **outpatient** basis must be registered with the hospital. The only exception to this is where there is a Private Practice Agreement in place that outlines the mutual expectations between the hospitals and the Professional Staff member.

### **III. Emergency Department Admission Principles and Guidelines**

Members of the Professional Staff shall comply with the approved [Emergency Department Admission Principles and Guidelines](#).

These guidelines are maintained in order to enhance patient care, access and flow, to remove disagreement between physicians regarding appropriate transfer of patients to services and to clarify the admission process in the Emergency Room.

### **IV. Discharges**

- a) A patient shall not be discharged from LHSC & SJHC except on a written discharge order signed by the MRP (or delegate). At the time of discharge the MRP (or delegate) shall ensure that the health record is complete, state the final diagnosis and either dictate or write a discharge summary on the form supplied for this purpose.
- b) Discharge orders shall comply with the approved policies:

[LHSC Discharge of Patients from Hospital Policy](#) and [SJHC Discharge of Patients from Hospital Policy](#)

### **V. Transfers**

- a) The transfer of responsibility from one Professional Staff member shall be acknowledged on the health record by all parties to the transfer, and the MRP transferring the responsibilities shall thereupon complete the health record to the date and time of transfer.
- b) In accordance with the Professional Staff By-Laws, responsibility for the care and treatment of a patient may be transferred to another member of the Professional Staff by the MRP or, upon direction of the patient, the chief of the appropriate medical department, the Vice President Medical, the Chair of the Medical Advisory Committee, or the President and CEO of LHSC & SJHC or delegate, shall be transferred to another member of the Professional Staff and the member to whom such responsibility has been transferred shall become the MRP.

## VI. Consultations

- a) The consultant shall examine the patient, record his/her findings, opinions and recommendations on the "consultation record" and sign and date same.
- b) Except in emergency conditions in which the delay in obtaining consultation would endanger the life of the patient, consultations shall be in accordance with the appropriate departmental policies or regulations.
- c) In addition to the foregoing comment, each Professional Staff member shall obtain a written consultation whenever requested to do so by the Chair of the Medical Advisory Committee, Chief of the department, Vice President Medical, or President and CEO of LHSC & SJHC or delegate.
- d) When a consultation is requested, the requesting Professional Staff member shall indicate their wish regarding the type of consultation.
  - (i) Consultation Alone - no follow-up requested or appropriate.
  - (ii) Consultation with Follow-Up Care - follow-up visits or contacts at appropriate intervals
  - (iii) Consultation with Concurrent Care - joint management with the MRP
  - (iv) Consultation and Transfer - consultant to have patient transferred to their care as MRP.
- e) When the consultant has assessed the patient, the consulting Professional Staff member will inform the requesting Professional Staff member regarding his/her willingness to provide the requested care. Irrespective of the type of consultation requested, it is the responsibility of the consultant to follow-up on any investigations that he/she has initiated and take appropriate action.

## VII. Hospital On-Call Guidelines

- a) On-Call Professional Staff members are expected to respond to a request for their services from SJHC or LHSC accordingly:
  - By telephone: within a maximum of 15 minutes
  - In person: within a maximum of 30 minutes, if the clinical situation requires
- b) The **on-call response time** is defined as the amount of time elapsing between the first successful notification of an on-call Professional Staff member (verbally or by pager) of the need for his/her services.
- c) Each Department will develop guidelines to be followed should the on-call Professional Staff member not be available in a timely manner. It is the responsibility of each Department to distribute the guidelines to appropriate key stakeholders (i.e. Switchboard).

- d) It is recognized that these are maximum times for on-call Professional Staff members throughout the institution. Individual departments may set out their own guidelines that fall within these maximums. It is further recognized that there may be rare and unusual circumstances in which the on-call Professional Staff member may be unable to respond within the times set out by these guidelines.
- e) These guidelines will be suspended in the case of unusual and acute short-term patient volume increases such as those experienced in a disaster response situation. The Vice President Medical, or the Chair of the Medical Advisory Committee (or their delegates) may suspend these guidelines.

### **VIII. Transfer of Patients Between Hospitals**

- a) Comprehensive information regarding ambulance and non-ambulance medical transfer services for London's hospitals is available at <http://www.lhsc.on.ca/priv/transprt/toc.htm>
- b) Patients shall be transferred from the care of a Professional Staff member at the sending hospital to the care of a Professional Staff member at the receiving hospital. The sending Professional Staff member or delegate should communicate directly with the receiving Professional Staff member prior to transfer and the receiving Professional Staff member must accept responsibility for the patient prior to transfer. Appropriate plans for medical care of the patient enroute should be developed. These arrangements shall be documented on the patient's health record.

### **C. DOCUMENTATION**

#### **I. Consent**

- a) Consent to treatment, including completion of the Consent to Treatment form, if appropriate, is required and must be obtained prior to the patient receiving the treatment. The Consent Policies for LHSC & SJHC can be found at: [LHSC Consent to Treatment Policy and Procedure](#) and [SJHC Consent Policy](#)
- b) Consent that has been given by, or on behalf of the patient for whom the treatment was proposed, may be withdrawn at any time by the patient/SDM.
- c) Treatment may be administered without consent only in an emergency situation, and then only following the guidelines for emergency treatment outlined in the [Health Care Consent Act](#) – Emergency Treatment.
- d) LHSC & SJHC requires a written consent form, signed by the patient/SDM and the Health Practitioner proposing and/or performing the treatment, for certain procedures, as outlined in the Consent to Treatment Policies.

- e) Written, informed consent is required for patients receiving or likely to receive blood and/or blood products. This would include, but is not limited to, ALL patients for whom a group and reserve or crossmatch has been ordered.
- f) Written, informed consent is required from patients/SDM before any [photography](#) is taken for any purpose, including:
  - a. Patient care
  - b. Education
  - c. Research
  - d. Public Relations
  - e. Media coverage

## **II. Deaths/Autopsies**

- a) Upon the death of a patient, the MRP (or delegate) shall complete all required documentation as prescribed by the [Public Hospitals Act](#), [Vital Statistics Act](#), and all other appropriate legislation and regulations, ensuring that such documentation is included in the Health Record. The MRP shall cause a copy of the Medical Certificate of Death to be filed in the Health Record within 24 hours after the death of the patient.
- b) Every Professional Staff member who has reason to believe that a person died:
  - i) as a result of violence, misadventure and negligence, misconduct, or malpractice;
  - ii) during pregnancy or following pregnancy in circumstances that might reasonably be attributed thereto;
  - iii) from disease or sickness for which he/she was not treated by a legally qualified Medical Practitioner;
  - iv) under other such circumstances as may require investigation;
  - v) by unfair means;
  - vi) from any cause other than disease;
  - vii) suddenly and unexpectedly;

shall immediately notify a coroner or a police officer of the facts and circumstances relating to the death. Refer to the [Coroner's Act](#).

Every Professional Staff member on the health care team should be aware of the value of the postmortem examination in terms of quality assurance. The human body or any part or parts thereof may be used for determination of the cause of death. Direction should be sought from the coroner in circumstances where a conflict arises between the Coroners Act and the intention to [donate organs](#) under the provisions of the [Trillium Gift of Life Network Act](#).

- c) All autopsies shall be performed by the Chief of Pathology or delegate unless otherwise instructed by the Coroner.
- d) Every patient/patient family has the right to request/authorize an autopsy. [Authorization for autopsy](#) shall be discussed with each dying patient, or family of a deceased patient, at LHSC.

- e) Policies regarding the [death of an indigent patient](#) (LHSC), care of body after death ([LHSC](#)), [disposal of limbs, tissues and organs](#) (LHSC) and [disposal following abortion, stillbirth or deceased neonate](#) (LHSC) should be reviewed for additional information.
- f) [Reporting of Deaths of Patients from LTC facilities to the Coroner](#): When persons who normally reside in a LTC facility die within 30 days of transfer to a hospital, each death must be reported to the coroner by completing the [Institutional Patient Death Record \(IPDR\)](#). The facility where the person was transferred from must be contacted for questions 6-9. If the answer to any of these questions is “Yes”, a local coroner must be notified directly and immediately.
- g) Any death at Parkwood hospital should refer to the [Parkwood Death Package](#), which includes a death procedure checklist, guidelines and special considerations related to death at Parkwood.

### III. Health Records

- a) **Introduction:** This section outlines Professional Staff documentation requirements in a patient’s health record in accordance with the Public Hospitals Act (R.R.O. 1990, Reg. 965), [Personal Health Information Protection Act \(PHIPA 2004\)](#) Accreditation Canada, Hospital By-Laws and Policies. It also incorporates linkages to general documentation principles for all health care providers responsible for documenting in a patient’s health record.
- b) **Definition of a Health Record:** A patient’s health record includes all information documented or recorded about a patient for the purpose of patient care. This includes but is not limited to pertinent facts of an individual’s health history, including all past and present health conditions, illnesses and treatments. It is related to the patient’s course of treatment while under the care of LHSC and/or SJHC, (hereafter referred to as “the hospitals”) and includes assessments, investigations, diagnoses, plan of care or treatment and interventions. It includes information that we generate, information that we have been provided to use by our Partner DPR/CDI hospitals and information we receive from other external sources. The official health record includes information maintained in the Health Records department, health information maintained in other areas of the hospital(s), as well as information stored and available for use in the electronic patient record system. If information is perceived by a health care provider (or researcher) to be relevant to the care of the patient it should be documented in the health record.

Every patient assessed, including research patients, treated or receiving care at the hospitals and all remote locations, shall be registered in the hospitals’ patient care system and an official health record will be created. Every patient visit to the hospitals will also be documented in the hospitals’ patient care system, creating an encounter number that is required for visit specific documentation to be recorded in the Electronic Patient Record (EPR). The only exception to this is where there is a Private Practice Agreement in place that outlines the mutual expectations between the hospitals and the Professional

Staff member.

The patient's health record includes all written as well as electronic documentation as well as images (including photographs, video) taken to document a patient's care. The patient's health record may be stored in hard copy, microfiche, microfilm, optical disk, and in digital or electronic format. The health record compiled in a hospital for a patient is the property of the hospital (as the Health Information Custodian of record) and will be kept in the custody of the administrator. The Health Records Department acts on behalf of the Administrator to carry out the organization's role as Health Information Custodian.

The official health record maintained by Health Record Services on behalf of the Administrator, must not leave hospital premises at any time, except under order of the Courts, Coroner's Warrant, to be moved between hospital sites for the purpose of ongoing care or when archived and relocated to the hospitals' inactive record storage facility or by written mutual agreement if LHSC or St. Joseph's transfers custodial responsibility for records to another individual or organization.

Transport of the official health record shall be coordinated by Health Record Services and occur only via approved transport as outlined in Health Record Services departmental procedure.

If, at any time, any agent of the Health Information Custodian finds it necessary to remove health information from the hospital premises in electronic form, it must be de-identified or encrypted. Absolutely no patient identifiable information shall be stored on desktop computers or mobile computing devices unless encrypted.

Patient's legal right to accuracy of personal health information: PHIPA grants patients the legal right to access their own personal health information (with only specific exceptions as directed in the Act and it's Regulations) along with the right that their personal health information be accurate. The Act and it's Regulations also grant patients the associated right to request an amendment or correction to information they consider to be inaccurate or incorrect. Personal Health Information Protection Act, 2004 Chapter 3, Part V and How Do I Correct My Personal Health Information and LHSC Privacy Policy and SJHC Privacy Policy describes the legal rights of patients along with the process to follow if a patient wishes to request an amendment to their PHI. The document also describes the conditions under which the Health Information Custodian may refuse to grant such a request and the process to follow to do so.

- c) **General Documentation:** The following general documentation principles are importantly noted here:
- i. All health care providers are responsible for documentation in the health record in accordance with legislative requirements, hospital policies and professional practice guidelines/standards.

- ii. The health record must be compiled in a timely manner and contain sufficient data to identify the patient, support the diagnosis or reason for encounter, justify the treatment and accurately document the results.
  - iii. All documentation in the health record must be complete, accurate and legible.
- d) **Inpatient Documentation:** In-patient documentation requirements can be found in the **“Documentation of Health Records Policy” (under development)**.
- e) **Outpatient Documentation:**
- i. The health record of an out-patient who visits the hospital solely for diagnostic procedures need only include the orders for the procedures, any consent to the procedures obtained in writing and a record of the procedures.
  - ii. All other outpatients’ health records will include: a note dictated/written for each visit by the MRP or delegate containing documentation as outlined in the Public Hospital Act.
- f) **Completion Requirements:** Chart completion requirements as outlined in the LHSC Chart Completion and Suspension of Privileges for Incomplete Charts Policy and the SJHC Chart Completion and Suspension of Privileges for Incomplete Charts Policy must be completed no longer than 14 days following discharge of the patient. The process for notifying physicians of charts that require completion and notices of failure to complete patient records is outlined in the Chart Completion Policy.

#### IV. **Orders**

- a) All orders for treatment shall be in writing and shall be signed by the MRP or delegate, except for orders as delegated under a medical directive. The MRP shall be responsible for the completion of all requisitions requiring clinical information. All such requisitions shall be completed as are necessary to ensure that all adequate work is completed.
- b) Telephone and Verbal orders (LHSC & SJHC) policy outlines the practices in place for the signing and countersigning of orders. In general, requisitions may be dictated by the MRP or delegate to a resident, or to such persons as are designated in writing by the President and CEO of LHSC & SJHC and may be accepted subject to review if any concern is indicated by the authorized receiving person. Such orders shall be recorded and signed by the person receiving them and shall contain the date, time, and the name of the Professional Staff member giving the order. Upon the Professional Staff member’s next attendance at LHSC & SJHC, any such order shall be signed by him and/or any Professional Staff member authorized by the MRP.

- c) A senior medical student (SMS) enrolled in the Schulich School of Medicine & Dentistry at The University of Western Ontario (SSMD), may prepare and sign orders for treatment based on the [LHSC Scope of Activities for Senior Medical Students Documentation and Orders Policy](#) and [SJHC Scope of Activities for Senior Medical Students Documentation and Orders Policy](#). It should be noted that all orders, written by a Senior Medical Student, for the investigation or treatment of a patient, must be done under the supervision or direction of a Physician, and must be **countersigned by the supervising physician prior** to the orders being processed and actioned.

#### **V. Self-Discharge**

When a patient insists upon leaving LHSC & SJHC against the advice of the MRP the patient shall be warned of the consequences of doing so. If the MRP or delegate is present, a statement describing the circumstances shall be entered by the MRP or delegate in the patient's health record and the patient shall be asked to sign a release form. ([LHSC Form NS0527 Leaving Hospital Against Medical Advice](#)) The MRP or delegate who writes the discharge order shall be responsible for the completion of the discharge summary.

For additional information, refer to the following policy: [LHSC Patient Rights and Responsibilities Policy](#)

#### **VI. Delegated Medical Acts**

- a) Refer to the delegation of medical acts policies for information regarding the procedure and process for the approval of a delegated controlled act:  
[LHSC Certification of Staff in the Performance of Delegated Controlled Acts Policy](#)  
[SJHC Delegation of Controlled Acts Policy](#)
- b) The College of the health profession accepting the delegation must have approved this transfer of function by its registered members in Ontario. Professional Practice Leaders (or their delegate - discretionary choice of the PPL) are responsible for ensuring the requirements of their respective disciplines regarding their Act are being met. For example, Professional Practice Leader for Nursing must ensure that the requirements of the Nursing Act related to delegated controlled acts are followed.
- c) All proposed delegations from Professional Staff members to other disciplines must be approved by Medical Advisory Committee. All proposed delegations from other disciplines must be approved by the Leader within LHSC and/or St. Joseph's who have accountability for Professional Practice Standards of that discipline, and be in accordance with the regulations of that College.
- d) Responsibility for carrying out delegated controlled acts is jointly the responsibility of the health professional delegating the act, the institution, the Program and its interdisciplinary team, as well as the individual accepting the delegation. It is the responsibility of the individual practitioner within the framework of a professional practice model to ensure his/her certification status is current, meeting the requirements of their professional College and the Regulated Health Professional Act ([Health Professions Regulatory Advisory Council](#)).

**VII. Medical Directives**

LHSC and SJHC have specific procedures and processes outlined regarding the use of medical directives, protocols, and pre-printed orders. Professional Staff members who wish to enact a new medical directive, protocol and/or pre-printed order must abide by the guidelines and process for approval. Any medical directive shall be reviewed every two years and shall be approved by the Medical Advisory Committee. Refer to: [LHSC Use of Medical Directives, Pre-Printed Orders Policy](#) and/or [SJHC Use of Medical Directives, Protocols & Pre-Printed Orders Policy](#) .

**D. TRAINEES - POSTGRADUATE AND CLINICAL FELLOWS**

**I. Supervision of Surgical Residents and Fellows in Operating Rooms: Urgent/Emergent (Board Cases)**

**(a) Post Graduate Trainees:**

Postgraduate Surgical Trainees may perform portions of procedures in the operating room without direct supervision if:

- (i) the MRP is in the same campus of the institution; and
- (ii) the MRP has personally informed the operating room staff of his/her location; and
- (iii) the post graduate trainee has the skill and knowledge to undertake that part of the procedure in the assessment of the MRP; and
- (iv) the patient is aware of the participation of the post-graduate trainee and has no objection.

**(b) Fellows:**

- (i) Each Department or Division Head must inform the Operating Room Administration, in writing, if a Clinical Fellow is sufficiently experienced that he/she may work independently. This documentation must include a list of procedures of which the Fellow is capable of performing. Documentation (Delineation of Surgical Privileges Clinical Fellow Status Form) will be part of the credentialing process and be maintained on file within Medical Affairs as per the Supervision of Surgical Residents and Fellows in Operating Rooms Urgent/Emergent (Board Cases) Policy
- (ii) The MRP is ultimately responsible for the care provided and for completion of an operating note in a timely fashion.
- (ii) Pursuant to the above, Fellows who work in the Operating Room without direct supervision by the MRP must meet the following conditions:
  - Documentation outlined under paragraph (i) is on file in Medical Affairs; and

- The Fellow has been appropriately credentialed by the Hospital Board; and
- The Fellow has successfully completed the Royal College Fellowship examinations or is American Board eligible; and
- The Fellow has appropriate CMPA coverage; and
- The Fellow has an appropriate Certificate of Registration from the CPSO; and
- The Patient (or their Substitute Decision Maker) has been informed and has given written consent to the Clinical Fellow to perform the surgical procedure. (This may be waived in the case of a life or limb threatening emergency.)
- The Fellow has discussed the case with the MRP prior to proceeding;
- The MRP is immediately accessible by telephone or pager and is available to assist “hands-on” within one half hour.

(iii) Concerns with respect to patient care provided as a result of this policy should be directed to the MRP/ and/or the Chief of Surgery and/or City-Wide Perioperative Executive Committee Chair.

## **II. Professional Staff-Resident Relationship**

- a) The relationship between professional staff members and residents is key to efficient patient care and imperative for a healthy work environment.
- b) Regular communication and consistent leadership is the best way to ensure the most effective relationship between staff and residents.
- c) It is important to note that a resident must notify the MRP if:
  - a. A patient is admitted to the hospital under the services of the MRP or transferred to a new MRP for elective or emergent purposes;
  - b. There is any significant change in the patient’s condition;
  - c. There is any unusual or unexpected finding;
  - d. The diagnosis or management is in doubt;
  - e. There are requests by patient and/or SDM (substitute decision maker)

The CPSO has set out policies for Professional Responsibilities in Postgraduate Medical Education and Guidelines for Supervision to clarify the roles & responsibilities of MRP’s, supervisors and trainees. All Professional Staff members should view the pdf document at: [Professional Responsibilities in Postgraduate Medical Education](#) & [Supervision Guidelines](#) for detailed information regarding the professional staff-resident relationship.

**E. SPECIAL AREAS, PATIENT TYPES AND MEDICAL PROCEDURES**

**I. Blood Transfusions**

The Blood Transfusion Laboratory webpage ([Blood Transfusion Laboratory](#)) is an excellent resource which includes physician information on blood products and risk of transfusion, patient information pamphlets, the Perioperative Blood Conservation Program, the Transfusion Manual and the Blood Order Guidelines for Adult Elective Surgery.

- a) The City-Wide Blood Transfusion Committee shall ensure a Transfusion Manual is maintained and updated appropriately.
- b) Members of the Professional Staff shall acquaint themselves and adhere to all policies and procedures regarding the prescribing and administration of all blood and/or blood products. All orders for blood products shall be in writing and signed by the MRP, or delegate. Refer to Section C IV(a) to IV(c) on documentation of orders in this document.
- c) The Blood Order Guidelines (BOG) for Adult Elective Surgeries should be followed when taking specimens for Group and Reserve or Crossmatch in the PreAdmit Clinic. The Blood Transfusion Lab will crossmatch according to these guidelines. Any surgery that is not on the list, or any change in the suggested orders must be specifically written by the surgeon, anesthesiologist or delegate in the patient chart.
- d) An order for blood product(s) that falls outside of the accepted guidelines for that blood product may be referred by the Blood Transfusion Laboratory (BTL) to the Medical Director of the BTL for review.
- e) Due to the risk associated with transfusion, the increasingly short supply of blood products and the fact that many patients would select an alternative to blood products if available, all attempts should be made to explore possible alternatives to transfusion of blood products
- f) Patients will be notified in writing if they have received blood and/or blood products. A copy of this correspondence will be placed in the patient's chart.

**II. Cardiac Care Unit**

The Cardiac Care Unit (CCU) shall be responsible for the care and treatment of patients known or suspected to have an unstable or potentially unstable cardiac disorder requiring monitoring under the supervision of a cardiologist who is normally the MRP.

**III. Paediatric (PCCU) & Adult Critical Care Units (CCTC, MSICU, CSRU)**

- a) The admission of patients to the Critical Care Units (PCCU & CCTC, MSICU, CSRU) is arranged in consultation with the on call attending physician of the critical care area or his/her delegate. If in the opinion of the critical care physician or his/her delegate the admission is not warranted, he/she must:

- b) See the patient immediately and state the reason for his/her refusal in writing. Any disagreement regarding an admission may be appealed to the Medical Director of the critical care unit. Unresolved issues in the PCCU regarding admission should be referred to the Chief of Paediatrics.
- c) Only patients who may benefit from the care provided by the critical care unit should be admitted. Refer to: [LHSC Admission of Patients to Critical Care Policy](#)
- d) Request for admission to the critical care unit by any member of the LHSC staff constitutes a request for consultation to the critical care unit on call physician or his/her delegate. The on call critical care unit attending physician shall be responsible for life support care, including assisted ventilation, administration of vasoactive drugs and other extraordinary therapies while the patient is in the critical care unit.
- e) *PCCU Note:* Children admitted with complex needs, often dependent on medical technologies for all or part of the day may be admitted to the Intermediate Care/ABI service. Postgraduate resident staff will be involved in the care of these patients only under exceptional or emergency circumstances.

#### **IV. Clinical Teaching Units**

- a) All patients under the care of members of the Professional Staff who are also Faculty at the Schulich School of Medicine & Dentistry at The University of Western Ontario shall be considered available for teaching purposes unless the patient indicates to the contrary.
- b) A patient who has not been designated a MRP shall be in the charge and care of a MRP designated by the Chief or Director of the appropriate Clinical Teaching Unit.

#### **V. Emergency Department**

- a) Patient's requiring admission to LHSC & SJHC will be admitted by a member of the Professional Staff designated by the patient, or if not so designated, will be referred by the emergency physician to the appropriate department or division/service. Refer to the [Emergency Department Admission Principles and Guidelines](#).
- b) The physician designated by the patient for registering the patient in the Emergency Department may be required by the President and CEO, or by the Medical Advisory Committee to justify the basis of the registration of the patient in the Emergency Department.
- c) A patient registered in the Emergency Department shall be the responsibility of:
  - i) the attending physician in the Emergency Department; or

- ii) the Professional Staff member who has referred a patient to the Emergency Department and who has examined the patient prior to his/her being referred to the department and who has properly and adequately informed the department as to the nature of the case and the treatment required; or
- d) Patients requiring dental consultations will be registered in the Emergency Department by a physician who is a member of the Professional Staff and designated by the patient. If no such designation is received from the patient, the patient will be registered in the Emergency Department by the staff emergency physician in consultation with the member of the Dental Staff designated by the patient, or if no such designation has occurred the patient will be referred by the emergency physician to a member of the Dental Staff, except in the case of oral maxillofacial surgeons who have admitting privileges.
- e) All orders for therapy, and all clinical impressions and findings, x-ray results, diagnoses, referrals and discharge orders shall be entered in the health record of the patient and signed by the MRP or designate.
- f) A registered patient shall not remain in the department for observation unless hospital beds are unavailable and approved by the emergency physician, provided that a registered patient may remain in the department for observation if in the opinion of the staff emergency physician or the MRP, the condition of the patient warrants observation for less than 24 hours. Also see [LHSC Bed Management Policy](#).

## VI. **Laboratory Medicine**

- a) Members of the Professional Staff shall acquaint themselves and adhere to all rules, regulations, policies and procedures regarding the use of the various laboratory services.
  - (i) Information regarding available services can be found on the London Laboratory Services Group (LLSG) web site ([London Laboratory Services Group](#))
  - (ii) All requests for laboratory tests must be signed on the patient's chart by a member of the Professional Staff or designate.
- b) Most laboratory tests which are required for immediate diagnosis or treatment of a patient are performed by either the Core Laboratory or the Blood Transfusion Laboratory (which are located on each of the acute care sites and operate 24 hours per day, 7 days per week). Tests performed in other specialized laboratories are only available during regular working hours, unless authorized by the Biochemist, Hematologist or Microbiologist on call. Certain low volume and highly complex tests are only performed at scheduled intervals which are listed in the Laboratory Test Information Guide ([Laboratory Test Information Guide](#)). If there are specific reasons for obtaining the test results sooner, the appropriate laboratory should be contacted to determine the feasibility of performing the test more quickly.
- c) Information regarding proper specimen collection, identification, handling and labelling requirements are available. Consult the [Specimen Collection Guide](#).

- d) **Priority Categorization** – The Laboratories process and test specimens based on priority results:
- **STAT** requests are reserved for medical emergencies. Requests for “stat” work will result in the sample being processed and reported in such a way as to minimize turnaround time. In general, the testing is completed within 1 hour of the laboratory receiving the specimen. It may be necessary to contact the relevant lab department for more information, since the service offered depends not only on the type of test, but also on the time of day and days of restricted staffing. The misuse of STAT orders causes delays in testing for all areas.
  - **ASAP** are for situations that are pressing, but are not emergencies – e.g. when wanting to discharge a patient prior to doctor’s rounds etc. These tests are completed before routine tests usually within 2 hours.
  - All other samples are considered routine.
- e) Professional Staff may request the addition of new tests. New tests will be added to the test menu if they are proven to be of benefit to patient care and cost effective. Contact the Medical Leader of the appropriate laboratory to request new test procedures and their benefits and costs.
- f) Lab results for outpatients will only be given over the phone after suitable identification of the requesting physician. Test results for inpatients are posted and available for look up on *Powerchart* once verified.
- g) Point of Care (POC) Testing must comply with the POCT policy, processes and procedures ([LLSG Point of Care Methods and Documentation](#)). POC testing results must be recorded in the patient’s medical record and be clearly distinguished from the laboratory test results. The patient must include the POC test result in clearly defined units, the date and time that the test was performed, the reference interval for the test and the identity of the person performing the test.
- h) [Critical laboratory values](#) policy states that critical values must be telephoned to the ordering physician or designate as soon as possible after completion of the test.

## VII. Long Stay Cases

- a) An Alternate Level of Care patient is one who has finished the acute phase of his/her treatment but remains in the acute care bed usually awaiting placement in a complex continuing care unit, long term care home, rehabilitation facility, other extended care institution, home care program, etc." (Provincial Definition of Alternate Level of Care). This also includes patients awaiting transfer to facilities for continuing care, e.g. convalescent facilities, or patients unable to be discharged home because of housing, household, economic or other family circumstances.
- b) Any patient at LHSC & SJHC occupying an acute care bed while awaiting an alternate level of care (ALC) must be reported to the Ministry of Health through appropriate documentation on the health record.

- c) The patient is classified and documented as "Alternate Level of Care" when the MRP or designate in consultation with the health care team indicates that a patient no longer requires acute care. The patient must be informed by the MRP or designate/ or a member of the health care team member that they no longer require acute care and have been designated ALC. See [LHSC Discharge of Patients from Hospital Policy](#) and [SJHC Discharge of Patients from Hospital Policy](#)
- d) The Alternate Level of Care form will be initiated by any team member (i.e. nursing, social work, PT, OT, etc) and signed by the MRP or designate.

### **VIII. Medical Legal Cases**

- a) Professional Staff members shall acquaint themselves with the hospital policies and procedures to be followed in the management of all cases with medical-legal implications. In particular, Professional Staff members should be familiar with current legislations related to consent to treatment, substitute decision makers, personal health information protection, quality of care information protection, as well as any mandatory reporting situations, e.g. suspected child abuse, gun-shot wounds. Refer to the [LHSC](#) and/or [SJHC policy](#) console on the website to access various policies on these topics.
- b) In the case of sexual assault,
  - the MRP shall be a medical practitioner designated by the patient or, if no practitioner is designated, or if designated and is unable to attend the patient, a member of the Sexual Assault Team Physician Roster shall be the MRP. For information:

#### [Regional Sexual Assault and Domestic Violence Treatment Centre](#)

- The MRP shall obtain a written consent using the prescribed form and perform all examinations, investigation of treatments.
- The MRP shall advise the patient that he/she should follow-up with his/her personal physician and that additional assistance is available from the Sexual Assault Program at St. Joseph's Hospital or such other agency, institution, or individual as the patient may desire.
- Refer to policies and/or procedures related to reporting child protection issues ([LHSC](#) & [SJHC](#)), and releasing of patient information to law enforcement.

#### [LHSC Release of Patient Information, Samples and/or Belongings to Law Enforcement Agencies Policy](#)

#### [SJHC Release of Patient/Resident/Client Information, Samples and/or Belongings to Law Enforcement Agencies](#)

### **IX. Mount Hope Centre for Long-Term Care**

- a) There shall be an appointed Medical Director of Long Term Care, recommended by the Medical Advisory Committee and selected by the Board on an annual basis, responsible for all medical activities at Mount Hope

Centre for Long Term Care (Marian Villa and St. Mary's sites), consistent with the Long-Term Care Facility Program Manual (MOHLTC), section 1012-01 ([Long-Term Care Facility Program Manual](#))

- b) The Medical Director, Long Term Care, shall be assisted in managing the medical and care delivery activities- Mount Hope by a Multidisciplinary Advisory Committee (the Long-Term Care Committee), which meets on a regular basis.
- d) The MRP shall be responsible for ensuring that medical coverage of the resident twenty-four hours a day, seven days a week is provided by licensed physicians with appropriate Canadian Medical Protective Association (CMPA) coverage. Such licensed physicians are not required to maintain membership on the hospital's Professional Staff for the purposes of on-call coverage or medical coverage for their patients admitted for respite care. Such licensed physicians should be readily available to nursing staff at all times. The MRP and the licensed physician shall cooperate with the activities and recommendations of the Medical Director of Long Term Care and the Advisory Committees.
- e) The MRP shall perform and duly record annually a complete medical assessment on the patient/resident.
- e) The MRP shall personally review in writing all physician orders every three months.
- f) The MRP shall visit the resident regularly and write appropriate progress notes in the resident's chart at least every three months. The frequency of a physician's visits is expected to reflect the resident's need for medical care.
- g) The MRP shall attend multi-disciplinary team meetings. These occur following admission (Admission Conference) and annually thereafter.
- h) Failure of the MRP to comply with these rules and regulations shall result in the following:
  - (i) the resident's care shall be temporarily transferred to the Medical Director of Long Term Care;
  - (ii) the physician's ongoing privileges to attend long term care residents shall be reviewed at the next meeting of the City-Wide Credentials Committee and subsequently at the Medical Advisory Committee of St. Joseph's Health Care, London; if the Medical Advisory Committee recommends that the physician continue to have these privileges, said physician shall be so informed and shall resume medical care of the patient/resident. If the Medical Advisory Committee recommends that the physician no longer be granted these privileges, said physician shall be so informed and the Medical Director shall assign care of the resident to a suitable physician with privileges at St. Joseph's Health Care.

**X. Operating Room**

- a) It is the duty of all Professional Staff to keep knowledgeable of and observe fully the policies of the operating room.
  - i) LHSC Policies can be found at: ([LHSC Operating Rooms Policy Manual](#))
  - ii) SJHC Operating Room Policies can be found at: ([SJHC Perioperative Nursing Resource](#))
  
- b) Operating rooms, facilities and equipment shall not used except strictly in accordance with the rules, regulations and policies established from time to time by the Perioperative Committee with the approval of the Medical Advisory Committee and the Board.
  
- c) There shall be established and maintained a Perioperative Committee which shall have duties and accountabilities as delineated by the Medical Advisory Committee with representation as specified by the Medical Advisory Committee.
  
- d) All operations shall be booked by the operating surgeon/oral maxillofacial surgeon (or delegate) after seeing the patient, and not by the referring physician. In all unilateral procedures, the involved side is to be noted on the operative booking list and this information is also to be written on the patient's physician record form and on the authorization for medical and/or surgical treatment. Evening, night, Saturday, Sunday and holiday booking shall be emergency and urgent and shall be made through the Operating Room Patient Care Coordinator or delegate.
  
- f) Each Department delineates [procedural privileges](#) outlining the scope of clinical practice granted to physicians appointed to the Professional Staff. Changes in operating room privileges shall require express consent from the chief of the department or division head, and must be in compliance with the specified operating room or surgical policy.

**XI. Surgery**

- a) While primarily responsible for histories, physical examinations and consultations is as stated in these rules and regulations, it is emphasized that the operating surgeon is ultimately responsible for seeing the required records are on the patient's clinical chart before he/she commences surgery.
  
- b) Except in extreme emergencies, the chart of every patient undergoing surgery shall, before surgery is commenced, contain diagnostic screening reports consistent with current, Pre-Admit Guidelines as determined by the Medical Advisory Committee
  
- c) It is the responsibility of the operating surgeon performing major surgery to ensure that the aid of a qualified assistant, a member of the resident staff or other physician is available.

- d) An individual will not be permitted
- to assist at surgery in any capacity unless credentialed and approved to do so by the President and CEO of the Hospital or delegate

An individual will be permitted

- to observe or be present in the Operating Room consistent with the guidelines communicated by the OR Manager. (Note: the development and implementation of a policy is currently under review).
- e) The operating surgeon is responsible for the post-operative care of the patient.
- f) The operating surgeon must see the patient regularly during the post-operative period and shall record the patient's progress appropriately on the chart.

#### **F. RESEARCH (CLINICAL)**

- a) Research on human subjects within Lawson Health Research Institute (LHRI) will be performed in accordance with nationally approved ethical guidelines recommended by the Tri-Research Council representing the Government of Canada. All research protocols involving human subjects will be submitted for review and approval by the UWO Research Ethics Board for Health Sciences Research Involving Human Subjects prior to any commencement of work. Given that the UWO Research Ethics Board recognizes the Ontario Cancer Research Ethics Board as the board of record for the approval of multi-institutional cancer trials, there are exceptions which allow some clinical research protocols for cancer patients to be conducted with Ontario Cancer Research Ethics Board review.
- b) Research at the LHRI is additionally performed in accordance with the Catholic Health Care Guidelines for human research where the location of research is within buildings owned and operated by SJHC. Research performed within buildings owned and operated by London Health Sciences Centre (LHSC) is not subject to faith-based ethical guidelines. LHRI refers emerging ethics issues from research not covered by existing guidelines to the Ethics Committees of SJHC and LHSC for informed advice. Such discussions would assess the likely implications of evolving new technologies and provide a forum for debate and education within the Institute, the London health community and in society at large.
- c) Research undertaken on animals is subject to review and approval by the University Council on Animal Care (UCAC) according to guidelines provided by the Canadian Council for Animal Care. Additionally, LHRI maintains its own animal care committee dealing with mainly functional issues related to animal research.

**G. CLINICAL**

**I. Medications**

- a) Both the LHSC and SJHC web pages ([LHSC Formulary](#)) and ([LHSC Medication and Pharmacy Resources](#)) and ([SJHC Pharmacy](#)) are excellent resources available to clinical staff as a resource for clinical care. These sites include medication information databases, Parenteral Administration Policies, the LHSC & SJHC Formularys, and other policies and procedures related to the prescribing and administration of pharmaceuticals.
- b) The Medical Advisory Committees, through the LHSC Drugs & Therapeutics Committee and the Pharmacy & Therapeutics Committee, shall ensure the preparation, maintenance, and updating of a Hospital Drug formulary.
- c) Members of the Professional Staff shall acquaint themselves and adhere to all rules, regulations, policies and procedures regarding the acquisition, prescribing, and administration of pharmaceuticals, including investigational, Special Access Program (SAP), emergency- released, and clinical trial drugs.
- d) A "non-formulary drug request form" must be completed and signed by the Professional Staff member, for all non-formulary drugs used at LHSC and SJHC. Non-formulary drugs are not routinely stocked in the pharmacy, and a delay of up to 48 hours is to be expected. The signed "non-formulary drug request form" is Pharmacy's authority to purchase the requested supply of medications for that specific patient. Usage of all non-formulary drugs will be reviewed by the respective Committees.

The following procedures should be noted:

- a) Nursing care, diagnostic tests and medication orders for each patient shall be recorded on the approved institutional order form;
- b) Medications shall be administered only upon the order of a Professional Staff member or their delegate, who has been assigned clinical privileges; or an individual who has been granted special prescribing privileges;
- c) Verbal/Telephone orders will comply with [LHSC Telephone and Verbal Orders Policy](#) and [SJHC Telephone and Verbal Orders](#);
- d) Each order must be clearly written, dated and signed by the prescriber in ink (not felt tip pen);
- e) Surgery automatically cancels all orders. All medication orders must be completely re-written post-operatively (Note: "Resume Pre-Op Meds" is not legally acceptable);

- f) Investigational Drugs include all drugs used in clinical trials (drug study) protocols regardless of whether they are standard of care, ancillary to the object of the study or the focus of the study. Drugs used in procedural studies which are not approved for such use are considered study drugs even though they are not the principle focus of the study. These may be:
  - i) drugs not yet approved by the Therapeutic Products Program (TPP) for general use;
  - ii) commercially available drugs being used in new dosage regimens, or for new indications;
  - iii) commercially available drugs being used in recognized doses and indications for the purpose of comparison with other available drugs or with new agents, or
  - iv) investigational drugs for one time use, or
  - v) drugs used in non-drug studies (e.g. procedural studies) which are not the normal standard of care.
- g) Investigational Drugs will be obtained, distributed and administered according to Policy.
- h) All Investigational Drugs and Clinical Trials/Studies will be approved by the Research Committee and P&T Committee before initiation, as well as the UWO Research Ethics Board and the relevant Impact Assessment Committee (e.g. CRIC, PIC).
- i) Pharmacy must be notified of all suspected adverse drug reactions. "An adverse drug reaction is any undesirable clinical response which might be due to any drug(s) and which is considered to merit reporting." Pharmacy will report all suspected adverse drug reactions to the Pharmacy and Therapeutics Committee and Health Canada.
- j) Senior Medical Students shall discuss, prepare and write orders based on the policy and processes outlined in ([LHSC Scope of Activities for Senior Medical Students – Documentation and Orders Policy](#)) and ([SJHC Scope of Activities for Senior Medical Students - Documentation and Orders Policy](#))
- k) Pharmaceutical Representatives must obtain permission from the Pharmacy Director, or designate to detail their products to Hospital Staff. Refer to **Pharmaceutical Representatives Policy (under development)**

## II. **Bed Management**

Members of the Professional Staff shall comply with the approved Bed Management Process.

At LHSC refer to the [Bed Management Policy](#) to review procedures and contingency plans to be enacted for critical bed shortages.

## III. **Infection Prevention and Control/Occupational Health**

- a) All Professional Staff shall comply with [Infection Prevention and Control policies and practices](#). It is the accountability of all Professional Staff members to familiarize themselves with these policies.

- b) All Professional Staff shall comply with [Occupational Health standards, policies and education](#). It is the accountability of all Professional Staff members to familiarize themselves with these policies and meet the requirements of Occupational Health Standards as required.

#### **IV. End of Life & Resuscitation Process & Procedures**

Regulated Health Care Professionals involved in the care of a patient are responsible for knowing the resuscitation plan and end of life decisions of the patient and communicating the plan to other members of the health care team. Refer to:

[LHSC End of Life Decision Making - Resuscitation Policy](#)

[LHSC End of Life Decision Making - Paediatric Advance Treatment Plan Policy](#)

[LHSC End of Life Decision Making - Limitation/Withdrawing of Life-Sustaining Treatment Policy](#)

[LHSC End of Life Decision Making - Provision of Appropriate Care Policy](#)

[SJHC End of Life Care/Palliative Care Policy](#)

[SJHC Resuscitation Decision Making Policy](#)

#### **H. MEDICAL COVERAGE**

##### **I. Procedural Privileges**

- a) Each member of the Professional Staff shall be assigned a particular privilege category that will delineate the extent of the Professional Staff member's privileges.
- b) All Professional Staff must be aware and adhere to their [departmental delineation of privileges](#).
- c) Any change in privileges requested by a Professional Staff member must be supported by the Chief of the relevant department.
- d) Any changes in privileges must be in compliance with the medical department requirements, particularly with regard to enhancement of privileges, and other relevant Hospital policies.
- e) Each department and division shall make recommendations through the City-Wide Credentials Committee, which has authority to accept/recommend changes to the Medical Advisory Committee, on the clinical procedures to be performed in each department or division that are outside the normal scope of training/experience for the members of the department/division.
- f) Under normal circumstances, any Professional Staff member who has a significant practice change such as a sudden reduction in clinical volume or alteration in case-mix must explain to the Medical Advisory Committee

the reasons for such a change. If the explanation is not considered satisfactory or conducive to efficient patient care or congruent with the mission and values of LHSC & SJHC, the Board may, at its discretion, suspend, revoke or limit the Professional Staff member's appointment.

## **II. Vacations/Leave of Absence**

- a) A vacation schedule shall be developed by the Professional Staff member and by each department to ensure appropriate medical coverage and continued functioning of the Health Centre during vacation times.
- b) Each Professional Staff member shall notify the Chief of the department (or delegate) of vacation plans at least two weeks prior to the vacation date. Longer notice periods may be established by the Department Chief if deemed appropriate to ensure continuing patient care.
- c) When a Professional Staff member is off for a [Leave of Absence \(LOA\)](#) (excluding vacations and continuing medical education) longer than 14 days, it is the Department Chief's responsibility to notify Medical Affairs, *in writing*. For departments with divisions, this responsibility can be delegated to the Division/Service Chief, with the understanding that the accountability of the LOA process within the department remains with the Department Chief.
- d) A leave of absence (excluding study leaves, parental leaves and sick leaves) greater than one year may be granted by the Board on the recommendation of the Medical Advisory Committee. The recommendations from the Medical Advisory Committee shall be with respect to the timing and duration of the leave as well as other conditions relating to the entitlement of privileges and the monitoring of the Professional Staff member upon his/her return from leave.
- e) Study leaves, parental leaves and sick leaves are an agreement between the Professional Staff member and the Chief of the Department.
- f) Where a Professional Staff member is on a leave of absence during the time for making an application for reappointment to the Professional Staff, he/she will not be required to make his/her application for reappointment until his/her return from leave.

## **III. Abuse of Hospital Privileges**

- a) When a member of the Professional Staff is attempting to exceed his/her privileges or is incapable of providing a service that he/she is about to undertake, this shall be communicated immediately to the Vice President Medical, Chair of the Medical Advisory Committee and/or President and CEO of LHSC & SJHC or delegate.
- b) Upon being informed of a Professional Staff member potentially exceeding his/her privileges, the Vice President Medical, Chair of the Medical Advisory Committee and/or President and CEO of LHSC & SJHC or delegate, may, at his/her discretion, prevent such procedures from taking place until such time as an investigation has taken place.

- c) An investigation shall be undertaken for all such incidents by the chief of the relevant department in consultation with the Chair of the Medical Advisory Committee and will be dealt with by the chiefs of the departments according to their function as defined in the Professional Staff By-Laws and Public Hospitals Act.

#### **IV. Medical & Non-Medical Observers**

- a) A member of the Professional Staff may request to have an observer accompany them while in LHSC and/or SJHC. Refer to the [LHSC](#) and [SJHC Observer](#) Policies for detailed information related to the responsibilities of the Professional Staff member (who acts as the Sponsor) and the Observer.
- b) An Observer is not permitted, in any circumstances, to provide any patient care.

#### **V. Withdrawal of Medical Services**

- a) Whenever there is a threatened withdrawal of services by a department or departments of the Professional Staff, the following steps will be taken:
  - i) the Chair of the Medical Advisory Committee, will call an emergency Medical Advisory Committee meeting;
  - ii) at this meeting the implications of any service withdrawals will be discussed and the appropriate action taken to minimize patient cancellations and service disruption and ensure overall patient safety;
  - iii) the Medical Advisory Committee, in its function of overall supervision of professional care, will continue to function during any service or threatened service withdrawal and it will effectively keep the President and CEO of LHSC and SJHC and the Board of Directors updated on the implications of any service withdrawal;
  - iv) the quality of medical care will be maintained at a satisfactory level for all in-hospital patients and those utilizing the emergency and out-patient services.

#### **I. ADMINISTRATIVE**

##### **I. Evaluation of Professional Staff**

- a) On an annual basis, each member of the Professional Staff shall be reviewed by the Chief or delegate of the department regarding recommendation for reappointment to the Professional Staff as set out in the Professional Staff by-laws. Each member of the Professional Staff shall participate in the Career Development and Planning process approved by the Medical Advisory Committee.

## **II. Professional Code of Conduct**

### **1. Ethics / Business Conduct**

- a) All Professional Staff working within LHSC and SJHC shall abide by the ethical policies/guidelines.
  - (i) All Professional Staff working within LHSC shall abide by the [LHSC Code of Conduct](#) and recognize how to address [ethical issues](#).
  - (ii) All Professional Staff working within St. Joseph's shall abide by the [Ethic Guidelines](#) and the Health Ethics Guide, published by the Catholic Health Association of Canada.
- b) All Professional Staff are expected to anticipate and avoid [conflicts of interest](#). Both LHSC and SJHC have Standards of Business Conduct ([LHSC / SJHC](#)) policies to specify appropriate business practices with regards to donors and all external and potential suppliers.
- c) Ethical policies and guidelines are inclusive of a number of areas where code of conduct and appropriate behaviours are expected and understood. Please refer to the following:  
[LHSC Harassment and Discrimination Policy](#) and [SJHC Workplace Harassment Policy](#)  
[SJHC Abusive Behaviour Toward Staff Guidelines](#)

### **2. Managing Complaints**

- a) In order to register a complaint against a member of the Professional Staff all complaints should be in writing, signed by the complainant and shall state clearly the nature of the complaint. Complaints registered by telephone to officers of LHSC & SJHC will be recorded in writing.
- b) In general, complaints shall be referred to the Patient Relations Coordinator at SJHC or the Patient Relations Specialist at LHSC, except those outlined in the Professional Staff By-Laws. ([LHSC Professional Staff By-Laws](#) and [SJHC Professional Staff By-Laws](#)). For additional information, refer to: [LHSC Management of Compliments and Complaints Policy](#)

## **III. Departmental and Committee Responsibilities**

- a) Practice requirements as established by each individual department must be met in order to maintain membership in a department. This may include such things as: on call, service to emergency, or time commitment to practice in the community.
- b) All Professional Staff may be required at the request of the Medical Advisory Committee, the Professional Staff Organization, or Medical Affairs to be involved in LHSC & SJHC committee activities.

**IV. Medical Department Review**

- a) Medical department reviews will be conducted at such time as agreed upon between the chief of the medical department and the Vice President Medical, and where appropriate, the Schulich School of Medicine & Dentistry at The University of Western Ontario.
- b) These reviews may encompass several components and will include any, or all, of the senior management group depending on the component being reviewed.
- c) Each chief will be required to report, on a regular basis, as required by the Medical Advisory Committee to the Medical Advisory Committee regarding activities, initiatives and issues of the particular medical department.
- d) All medical departments must submit, through the Vice President Medical, an annual report identifying progress, achievements, and a general review of activity over the previous fiscal period. This report should also include specific objectives for the coming year.
- e) On an annual basis or at such time as mutually agreed upon between the Vice President Medical, and the Chief of the department, a performance review of the Chief's administrative activities will be conducted.
- f) On an annual basis, as part of LHSC & SJHC's overall operational planning process, medical departments will work in conjunction with LHSC & SJHC departments to develop short and long term goals regarding quality, operations, program development, manpower plans, and capital requirements.

**V. Limiting Professional Staff Appointments**

- a) The policy of the Board of LHSC & SJHC will be to limit the appointment of Professional Staff members to any department of LHSC & SJHC either entirely or to certain categories. The Medical Advisory Committee, in response to Board policies, LHSC & SJHC Strategic Plan, the Professional Staff Rules and Regulations, departmental medical manpower plans, and any other relevant Health Centre policy and procedures, may recommend to the Board limitations on Professional Staff appointments under circumstances consistent with the Professional Staff By-Laws.
- b) Proposed limitations to Professional Staff privileges will be initiated through the Chiefs of divisions/services to the Chair of the Medical Advisory Committee. The Medical Advisory Committee will consider the rationale of any such proposed limitations and will make recommendations to the Board.

**VI. Reappointments**

- a) Each application for reappointment shall be in accordance with the Professional Staff By-Laws, Section 2.05 ([SJHC Professional Staff By-Laws](#)) ([LHSC Professional Staff By-Laws](#))

**VII. Appointment of Chiefs of Department**

- a) Appointment of Chiefs of Department shall be in accordance with the Professional Staff By-Laws, Section 6.03 ([SJHC Professional Staff By-Laws](#)) ([LHSC Professional Staff By-Laws](#))

**J. PATIENT RIGHTS AND RESPONSIBILITIES**

**I. Patient Rights, Dignity and Independence**

- a) LHSC & SJHC believes in and encourages a partnership between patients and their health care providers. Each patient's role as a member of this partnership is to understand and exercise his/her rights and responsibilities. A commitment to ensuring patient involvement in decision making, access to therapies of choice and accountability to providing a safe environment for patients, visitors and hospital staff is essential. LHSC & SJHC has developed guidelines and policies to support these principles. All members of the Professional Staff should be familiar with these policies and guidelines. Please refer to: [LHSC Corporate Policies Web Page](#) and [SJHC Corporate Policies Web Page](#)
- b) The privacy and confidentiality of all patients/residents/clients will be protected. LHSC & SJHC have consistent policies that provide direction to Professional Staff on privacy and confidentiality issues. Professional Staff can utilize the Privacy Office as a resource for privacy and confidentiality issues and must contact the Privacy Office if patients' personal health information is compromised, i.e. lost, stolen or accessed without authority. Refer to the [Privacy Office](#) website for policies and guidelines related to privacy and confidentiality.

**K. AMENDMENTS**

- a. From time to time the MAC shall approve amendments to the Professional Staff Rules & Regulations.
- b. Such amendments, when so enacted or necessitated by other changes to titles, staffing, governance or organization within the LHSC or St. Joseph's shall form part of the Rules & Regulations as a whole. This includes non-substantive changes and amendments as are reasonably required for consistency, accuracy and ease of reference.