Medical Staff Rules

Interior Health Authority

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Index

Preamble

This document comprises the Medical Staff Rules (the "Rules") of the Interior Health Authority (IHA), and applies to all members of its Medical Staff, whether independent practitioners, contracted practitioners or employees. The Rules provide specificity and detail to the articles of the IH Medical Staff Bylaws[1] (the "Bylaws"). In the case of an inconsistency between these Rules and the Bylaws, the provisions of the Bylaws shall prevail.

The Hospital Act Regulation[2] requires the Board to organize a Medical Staff in accordance with the IHA Medical Staff Bylaws and Rules, and in compliance with the IH's published Bylaws, Policies and procedures. The Board grants Privileges to appropriately qualified Medical Staff members to ensure effective care delivery in the facilities and programs operated by IH.

The Board is ultimately accountable for the quality of care delivered in the Facilities and Programs operated by IHA. This accountability extends to the Chief Executive Officer (CEO), who is the Board's representative, as outlined in Section 3(1) of the Hospital Act Regulation[2]. Members of the Medical Staff are accountable to the CEO and Board, through the Health Authority Medical Advisory Committee (HAMAC), for the quality of medical care they provide in the facilities and programs operated by the IHA. The primary role of the HAMAC is first, to assure the Board that the quality of medical care meets an acceptable standard; second, to recommend Medical Staff appointments to the Board; and third, to govern the Medical Staff based on the Medical Staff Bylaws, Rules and Policies.

The Rules are established by the Board upon the recommendation of the HAMAC pursuant to Article 12 of the Bylaws. Whereas a change to the Bylaws requires approval by the Minister of Health, the Board has the authority to approve or amend the Rules after receiving the recommendation of the HAMAC. As such, the Rules can be adapted expeditiously to reflect ongoing changes in Medical Staff practice and governance. The Rules amendment process is set out in Article 12 of the Bylaws.

The Rules govern the relationship between IH and its Medical Staff and address the accountability of Medical Staff for their day-to-day practice within IHA. The Rules assist the Medical Staff to discharge their responsibilities to the Board by establishing standards and processes that define the function and deportment of the Medical Staff.

Members of the Medical Staff are required to adhere to, and are offered the protections of, the B.C. Freedom of Information and Protection of Privacy Act (FOIPPA) and other applicable legislation respecting personal privacy. Further, Medical Staff are afforded the protection of the Public Interest Disclosure Act (PIDA), promoting public accountability and transparency.

1. Medical Staff Bylaws. Interior Health Authority, Board Manual 9.1.
https://www.interiorhealth.ca/sites/default/files/PDFS/medical-staff-bylaws.pdf
2. Hospital Act Regulation.
https://www.bclaws.gov.bc.ca/civix/document/id/crbc/crbc/121_97

ARTICLE 1 – PURPOSE

As outlined in the Bylaws, Article 2, the purpose of the IHA Medical Staff is to act in an advisory capacity to the Board of Directors, being accountable for the quality of medical care provided in the programs and facilities of the IHA. Through a variety of functions (Article 2.2, Bylaws) the IHA Medical Staff can fulfill this accountability. Further, the professional conduct of the members of the IHA Medical Staff is governed by each profession's Code of Ethics, as detailed in Bylaws, Article 2.3.

The IHA Medical Staff are representatives of the strengths and diversity with Interior Health communities, both urban and rural centres. The IHA Medical Staff work cohesively and collaboratively to provide equitable patient- and family-centred care through the Region. As representatives of their communities, the IHA Medical Staff espouse the highest quality medical care and professionalism.

The IHA Medical Staff supports the provision of medical care built around the patient and family receiving health care services. The IHA Medical Staff support the Interior Health Framework for Person- and Family-Centred Care, which places individuals at the forefront of their health and care, ensures they retain control over their health care choices, helps them make informed decisions, and values the patient as a partner in health care provision and redesign of services.

The IHA Medical Staff promotes diversity, equity, inclusion and belonging, for all Medical Staff, employees, volunteers, patients, and families. The IHA Medical Staff recognizes that diversity in the workplace shapes values, attitudes, expectations, perception of self and others and in turn impacts behaviours in the workplace. The dimensions of a diverse workplace includes the protected characteristics under the human rights code of: race, color, ancestry, place of origin, political belief, religion, marital status, family status, physical disability, mental disability, sex, sexual orientation, gender identify or expression, age, criminal or summary conviction unrelated to employment (IHA Policy AU2100).

The IHA Medical Staff are committed to ensuring that all individuals, whether patients, clients, residents, visitors or staff, are treated with dignity and respect, free from discrimination and harassment; and supported in the respectful management of any workplace conflict. To this end, the IHA Medical Staff are required to conduct themselves, and to be treated, in accordance with the IHA Standards of Conduct for Interior Health Employees (IHA Policy AU0100).

The IHA Medical Staff are committed to Culturally Safe care, as defined by Interior region Indigenous peoples. IHA Medical Staff are committed to delivery of health services that are accessible, of high quality, relevant, culturally safe, and provided in a culturally competent manner (IHA Policy AD0200). Further, IHA Medical Staff are committed to addressing Anti-Aboriginal Racism and breaches of Cultural Safety, and activity engaging in Anti-Racism, in alignment with the IH Anti-Racism policy (IHA AU 2200).

The IHA Medical Staff are committed not only to high quality clinical care, but to education and research. IHA Medical Staff are committed to the clinical education of medical students, residents, fellows and other clinical trainees in the IHA Facilities and

Programs. Further, IHA Medical Staff strongly support research and improvement activities to further study, enhance and improve the quality of care provided.

The IHA Medical Staff and Interior Health acknowledge their shared commitment to deliver high quality care in a healthy workplace and consequently, our shared understanding of our respective responsibilities. Further, the IHA and Medical Staff promote the principles and practices of a Just Culture and procedural fairness in both patient safety reviews, individual accountability reviews and disciplinary processes. This shared understanding and commitment is reflected in the Interior Health Authority / Medical Staff Charter (**Appendix A**).

ARTICLE 2 – DEFINITIONS

Affiliation Agreement **—** An agreement between the IHA and a University, College or other educational entity to facilitate teaching and clinical-training activities within an IHA Facility or Program.

Appointment **—** The process by which a Physician, Dentist, Midwife or Nurse Practitioner becomes a member of the IHA Medical Staff. Appointment does not constitute employment by the IHA.

Associate Department or Program **—** A second Department or Program, other than the Primary Department or Program, with which a member of the Medical Staff may be affiliated.

Attending Medical Staff **—** The physician, midwife, dentist or nurse practitioner who is the primary caregiver for a patient admitted to or treated in an IHA Facility or Program (see "***Most Responsible Practitioner"***).

Board of Directors (the Board) **—** The governing body of the Interior Health Authority appointed by the Minister of Health for the Province of British Columbia (BC).

Chief Executive Officer (CEO) **—** The person engaged by the IHA Board to provide leadership to the Health Authority and to carry out the day-to-day management of the Agencies, Facilities and Programs operated by the IHA in accordance with the Bylaws, Rules and policies of the IHA.

Chief of Staff **—** Also called the **Senior Facility Medical Administrator,** a member of the Active Medical Staff appointed to be responsible for assuring the professional deportment and quality of medical care provided by members of the Medical Staff within a Facility, and for providing local medical leadership and advice to facilitate operational decision-making.

Computerized Provider Order Entry (CPOE) **—** The process of order placement into the electronic health record by a healthcare provider or designated Medical Staff member, employing either single electronic orders or groups of orders (electronic clinical order sets).

Credentialing **—** The process of screening and evaluating Medical Staff qualifications, including appropriate training, licensure, experience, references, professional college requirements and malpractice insurance necessary for appointment to the IHA Medical Staff. The Credentialing process requires, in part, Medical Staff compliance with competency expectations outlined in the Provincial Privileging Dictionaries for the Province of BC.

Delegated Medical Act **—** A medical act that, endorsed by HAMAC and approved by the Board, with the agreement of the relevant medical department(s) and the IHA Practice and Regulations Advisory Committee (PRAC) has been transferred to another (regulated or unregulated) healthcare professional.

Department **—** An organizational unit of the Medical Staff to which members with a similar practice or specialty have been assigned.

Department Head — A member of the Active Medical Staff appointed by the IHA and responsible to the Senior Executive Medical Administrator (Vice-President Medicine) or Senior Nursing Administrator (in the case of Nurse Practitioners) to lead the clinical, academic, quality improvement and governance activities of a Department.

Dentist — A member of the Medical Staff who is duly licensed and registered with the College of Dental Surgeons of B.C. and who is entitled to practice dentistry in British Columbia.

Division — A component of a Department or Program composed of members with a clearly defined sub-specialty interest.

Division Head — A member of the Active Medical Staff appointed by and responsible to a Department Head to lead the clinical, academic, quality-improvement and governance activities of a Division.

Electronic Health Record (EHR) — A secure, integrated, digital collection of a patient's medical information and encounters with the healthcare system, comprising a comprehensive digital record of that individual's health history.

Executive Medical Director (EMD) — A physician appointed by the Senior Executive Medical Administrator, responsible for the coordination and direction of the activities of the Medical Staff within a Region or Program.

Facility — A healthcare site operated by the IHA.

Health Authority (HA) — One of five geographical entities and one strategic entity, led by a government-appointed Board, to oversee the provision and management of healthcare services and delivery in BC. Geographical HAs are established under the *BC Health Authorities Act* or the regulations thereto, while the Provincial Health Services Authority (PHSA) is established under the *BC Society Act.*

Health Authority Medical Advisory Committee (HAMAC) — The senior medical committee, advisory to the IHA Board and CEO, on medical, dental, midwifery and nurse practitioner governance and practice matters, including quality-of-care issues, as described in Article 8 of the Bylaws.

Health Record — A digital or hard-copy version of the patient medical chart.

Hospital — A health care facility defined in the *Hospital Act* and owned or operated by the IHA.

Local Medical Advisory Committee (LMAC) — The medical advisory committee of a Facility or part of a regional service delivery area that reports to the HAMAC on local medical, dental, midwifery and nurse practitioner matters, as described in Article 8 of the Bylaws.

Medical Advisory Committee (MAC) — A general term describing any LMAC, RMAC and the HAMAC operating within the IHA (see specific definitions elsewhere in this section).

Medical Affairs — An administrative branch of the IHA, within the **Senior Executive Medical Administrator (Vice President Medicine)** portfolio. Part of the responsibility of **Medical Affairs** is to assist the HAMAC, RMACS, LMACs, Departments and Programs to fulfill their obligations regarding Medical Staff organization, hiring and workforce planning, and governance.

Medical Care — The clinical services provided by Physicians, Dentists, Midwives and Nurse Practitioners to IHA patients and clients.

Medical Director — A physician appointed by the Senior Executive Medical Administrator, responsible for the coordination and direction of the activities of the Medical Staff within a Region, Program, Network or Portfolio. Includes **Senior Medical Director (SMD)**.

Medical Staff — The Physicians, Dentists, Midwives and Nurse Practitioners who have been granted a permit to practice by the Board in the Facilities and Programs operated by the IHA.

Medical Staff Association — The component of the Medical Staff Organization, established by Article 10 of the Bylaws, to represent the Medical Staff and to ensure effective communications between the Medical Staff, administration, and the Board of Directors fo the IHA. All members of the Medical Staff belong to and fulfill the responsibilities of the Medical Staff Association.

Medical Staff Bylaws (the Bylaws) — The bylaws, approved by the HAMAC, Board and BC Minister of Health, which set out the organization, structure, function, governance and accountability of the IHA Medical Staff.

Medical Staff Organization —The membership of the Medical Staff including every practitioner providing care in the Facilities and Programs of the IHA, organized in accordance with the *Hospital Act and its Regulation.*

Medical Staff Policy — Administrative guidelines or policies establishing standards for the delivery of medical care to patients within the Facilities and Programs operated by the IHA.

Medical Staff Rules (the Rules) –– These Rules, promulgated as per Article 12 of the Medical Staff Bylaws and approved by the Board, governing the day-to-day management of the Medical Staff in the Facilities and Programs operated by the IHA.

Midwife — A member of the Medical Staff who is duly licensed by the College of Midwives of B.C. and who is entitled to practice midwifery in British Columbia.

Most Responsible Practitioner (MRP) –– the member of the Medical Staff who has the overall responsibility for the management and coordination of care for a patient admitted to, or being treated in, a Facility or Program operated by the IHA. The MRP shall be an Active or Provisional Medical Staff member who is a Physician, Midwife, Dentist or Nurse Practitioner.

Network — An IHA organizational structure that focuses on a patient population with similar conditions, such as mental health and substance use, or a specific type of clinical practice, such as trauma or emergency-department care.

Nurse Practitioner — A nurse who is duly registered with the B.C. College of Nurses and Midwives as a Nurse Practitioner and employed by IHA to practice as a Nurse Practitioner, subject to applicable legislation, in the facilities owned or operated by IHA.

Physician — A member of the Medical Staff who is duly licensed by the College of the Physicians and Surgeons of B.C. and who is entitled to practice medicine in British Columbia.

***Practitioner* —** A Physician, Dentist, Midwife or Nurse Practitioner who is a member of the IHA Medical Staff.

***Primary Care Practitioner* —** A physician who has been granted a Fellowship or Special Certificate by the College of Family Physicians of Canada, or its equivalent in a non-Canadian jurisdiction; or a physician with relevant clinical experience who is licensed to practice as a Family Physician by the College of Physicians and Surgeons of B.C.

***Primary Department* —** The Department to which a member of the Medical Staff is assigned, based on training and the specialty in which the member delivers the majority of care to patients.

***Privileges* —** A permit to practice medicine, dentistry, midwifery or nursing as a Nurse Practitioner in the Facilities and Programs operated by the IHA and granted by the Board to a member of the Medical Staff, as set forth in the *Hospital Act and its Regulation*. Privileges describe and define the scope and limits of each practitioner's permit to practice in the Facilities and Programs of the IHA. Privileges are site-specific.

***Program* —** A care-delivery structure, focused on co-ordinating and delivering a specific type of patient care under the jurisdiction of the IHA.

***Provincial Privileging Dictionaries* —** Standardized province-wide privileging standards for Medical Staff practicing in all British Columbia Health-Authority Facilities.

***Regional Medical Advisory Committee (RMAC)* —** A medical advisory committee reporting to the HAMAC, established in each of the IHA's Health Service Delivery Areas, having delegated responsibilities and Terms of Reference approved by the HAMAC.

***Regulatory Body* —** The discipline-specific BC provincial regulatory college for each category of the Medical Staff.

***Reserved Medical Act* —** A medical act or function which, under the scope of practice as currently approved by the Minister of Health of BC, may be performed only by a member of the Medical Staff.

***Resident* —** Resident Staff are qualified physicians, dentists, midwives or nurse practitioners who are undergoing training, and who are temporarily attached for educational purposes to a Facility or Program operated by the IHA. Resident Staff are not members of the Medical Staff as defined in the Bylaws and therefore are not governed by these Rules.

***Senior Executive Team (SET)* —** The primary planning, strategic-management and decision-making team supporting the CEO of the IHA.

***Senior Executive Medical Administrator* —** The senior administrative physician of the IHA, usually titled the **Vice President Medicine**, appointed by the CEO, responsible for the oversight, coordination and direction of the activities of the Medical Staff.

***Senior Executive Nursing Administrator* —** A registered nurse, appointed by the CEO of the IHA, usually titled **Chief Nursing Officer** (CNO) who has Health Authority wide responsibility and accountability for providing senior leadership and strategic direction for the professional practice of Nursing and Allied Health.

***Senior Facility Medical Administrator* —** The senior administrative physician of an IHA Facility, often referred to as the **Chief of Staff**.

Senior Operational Administrator — The person engaged by the IHA to provide leadership to an IHA Facility or Program to oversee the day-to-day operations and management of the Facility or Program. Often, this is an **Executive Director** or **Director**.

Specialist — A physician who has been granted a Fellowship or Special Certificate by the Royal College of Physicians and Surgeons of Canada, or its equivalent in a non-Canadian jurisdiction; or a physician with relevant clinical experience who is licensed to practice as a Specialist by the College of Physicians and Surgeons of B.C.

ARTICLE 3 — CATEGORIES OF MEDICAL STAFF

Medical Staff categories are identified and defined in Article 6 of the Bylaws, which should be referenced for detailed information. These Rules provide further details about some of these categories. The Medical Staff categories are as follows:

3.1 **Provisional Staff**:

The initial appointment for all applicants seeking active staff privileges, unless specifically exempted from this requirement by the Board. This category may also apply to members of the Medical Staff who are under review or have been disciplined.

3.2 **Active Staff**:

The preferred category for appointment to the IH Medical Staff, with specific rights and obligations that correspond with this appointment.

3.3 **Associate Staff**:

A restricted appointment to the Medical Staff for members may utilize diagnostic facilities, assist in the operating room or undertake other duties specifically assigned to them, but who shall not perform surgical or investigational procedures for which additional privileges are required.

3.3.1 **Clinical Associate Staff**

3.3.1.1 The Clinical Associate Staff are a specific category of the Associate Staff.

3.3.1.2 Members of the Clinical Associate Staff are appropriately qualified, credentialed and privileged Medical Staff who work in highly-specialized areas under the direction of a Department or Division Head, or a senior member of a Department or Division, who acts as their sponsor and is responsible for their work. The Department or Division Head shall define their scope of practice.

3.3.1.3 Members of the Clinical Associate Staff must satisfactorily complete the required period on the Provisional Staff as described in Section 6.1 of the *Bylaws*, unless exempted from that requirement by the Board.

3.3.1.4 Members of the Clinical Associate Staff provide clinical services and are not part of a clinical training program.

3.3.1.5 Members of the Clinical Associate Staff are assigned to a Primary Department and may not admit patients to the Programs and Facilities operated by the IHA, but may attend, investigate, diagnose and treat patients within the scope of their privileges.

3.3.1.6 Members of the Clinical Associate Staff are not eligible to hold office and vote at Medical Staff and departmental meetings.

3.3.1.7 Unless specifically exempted by the HAMAC, members of the Clinical Associate Staff are required to participate in fulfilling organizational and service responsibilities, including on-call responsibilities as described in these *Rules*.

3.3.1.8 Members of the Clinical Associate Staff are required to participate in administrative and educational activities of the Medical Staff and are required to attend at least 70 percent of Primary Departmental or Divisional meetings.

3.3.1.9 Appointment to the Clinical Associate Staff conveys no preferential status or privilege in seeking a future appointment to any category of the Medical Staff.

3.3.2 **Clinical Fellows**

3.3.2.1 Clinical Fellows are a specific category of the Associate Staff.

3.3.2.2 Clinical Fellows are physicians who have applied to and been accepted by the IHA for further training, upon recommendation from the IH Department Head.

3.3.2.3 Along with standard privileging process and documentation as outlined in the *Bylaws*, Clinical Fellows must be registered with the Faculty of Medicine, University of British Columbia.

3.4 **Consulting Staff:**

Physicians, Dentists, Midwives and Nurse Practitioners with special training or other qualifications in a particular discipline, who have been recommended by the HAMAC to be of special advantage to the Facilities and Programs operated by the Interior Health Authority.

3.5 **Temporary Staff**

3.5.1 The purpose of an appointment to the Temporary Staff is to fill a time-limited-service need. General details are outlined in Article 6.5 of the *Bylaws*.

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

3.5.3 Under normal circumstances, a Temporary Staff appointment must follow the policies and procedures employed for any other Medical Staff appointment.

3.5.4 In special or urgent circumstances, where Temporary Staff may need to be appointed quickly, the Senior Executive Medical Administrator, on the authority of the CEO, may grant interim Temporary Privileges for a specified purpose and period of time. Examples include:

i. Privileging required for organ retrieval;

ii. Demonstrating equipment or new procedures;

iii. Providing care during mass casualties; or

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

3.5.5 This Temporary Staff appointment must be ratified or terminated by the Board at its next scheduled meeting.

3.6 Locum Tenens Staff

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

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

3.6.2 A Provisional, Active or Consulting Staff member must advise the Medical Affairs Department of the specific dates of any upcoming Locum Tenens requirement. The request must be approved by the Department or Division Head in advance.

3.6.3 Members of the Locum Tenens Staff may only replace an absent member of the Provisional, Active or Consulting Staff. In this context, "absent" means being away from a Facility or Program-based practice for vacation, parental, educational, illness or Board-approved leave of absence.

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

3.6.5 A request for Locum Tenens Staff for a period of less than 48 hours shall only be approved in urgent circumstances, as determined by the Senior Executive Medical Administrator, or designate.

3.6.6 While Locum Tenens Staff Privileges may be granted for up to twelve months, each new period of locum coverage must be approved in advance. When the approved period of coverage concludes, Locum Tenens Staff cannot continue to exercise their

Privileges. For each subsequent Locum Tenens coverage period, a Provisional, Active or Consulting Staff Member must submit a completed locum scheduling form to the Credentialing and Privileging Office of IH Medical Affairs, confirming coverage dates. This must be approved by the Department or Division Head prior to Locum Tenens Staff exercising their Privileges.

3.6.7 Minimum lead times for Locum Tenens category Privileges are:

3.6.7.1 New Applicants: six weeks
3.6.7.2 Current Locum Tenens Staff requesting additional site Privileges: two weeks.

3.6.8 In situations requiring urgent Locum Tenens appointment, the Senior Executive Medical Administrator, or designate, may grant Temporary Privileges while the application is being processed.

3.6.9 Upon approval by the Division or Department Head, for applicants who have not previously held IHA Medical Staff Privileges, the Medical Affairs Department shall provide an application package for new Locum Tenens Privileges. The completed application package must be approved by the Department or Division Head, following which it shall be forwarded to the HAMAC by the Medical Affairs Department for a recommendation to the Board for approval.

3.6.10 <u>Responsibilities of the Medical Staff Member Requesting a Locum</u>

i. The Medical Staff member shall notify the Medical Affairs Department of an upcoming Locum Tenens arrangement by forwarding the completed locum scheduling form, indicating start and end dates, within the required minimum lead time.

ii. The Medical Staff member must be absent from the hospital or Facility for the full period of locum coverage, except to facilitate orientation and patient handover.

iii. The Medical Staff member is responsible to arrange the orientation of the Locum Tenens to the Facility or Program, including orientation to program policies and procedures required to support provision of care to patients. If the Medical Staff member is unavailable to fulfil these responsibilities, the Department or Division Head shall assign the responsibility to another member of the Medical Staff.

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

v. The Medical Staff member requesting the Locum Tenens shall complete a performance appraisal as soon as possible after the locum has finished. This shall be forwarded to the Medical

Affairs Department for future reference and follow-up, if necessary.

vi. The Medical Staff member is responsible for the completion of any Health Records the Locum Tenens fails to complete while providing coverage.

3.6.11 Responsibilities of the Locum Tenens

i. Locum Tenens Privileges are granted to an individual practitioner for a defined period of time.

ii. Where the EHR has been deployed, the IHA shall ensure that the prospective Locum Tenens has access to adequate EHR training and, in turn, the new Locum Tenens must ensure EHR education training has been completed and competency has been achieved. Failure to do so may result in not receiving Privileges in time to cover the requested locum.

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

iv. Locum Tenens Staff may not assign their locum coverage to another practitioner with Locum Tenens Privileges, unless that assignment is part of a regularly-scheduled on-call.

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

3.7 **Scientific and Research Staff:** qualified researchers or educators who, in recognition of their training, experience and ability, have been granted this appointment to carry out duties related to teaching and research assigned to them by the head of the Department to which they have been appointed. Members of the scientific staff must not admit patients, write orders, vote, or be officers of the Medical Staff Associations.

3.8 **Honorary Staff:** Medical Staff members not active in the Facilities and Programs operated by the IHA, but whom the Board of Directors wishes to honour. This category may include individuals with outstanding reputations or prominent physicians, dentists, midwives or nurse practitioners who have retired. Honorary Staff are not privileged to practice in the Facilities and Programs operated by IH, and they have none of the Departmental responsibilities or rights that apply to other categories of the Medical Staff.

ARTICLE 4 — MEMBERSHIP AND APPOINTMENT

4.1 Membership

4.1.1 Terms and criteria for appointment to the Medical Staff, as well as procedures for application and review, are detailed in Articles 3 and 4 of the *Bylaws*. The IHA supports and strives for consistency and transparency in all these processes.

4.1.2 Appointments to the Medical Staff are Health Authority wide. Each appointment shall describe the scope and limits of the Medical Staff Member's permit to practice in a Facility or Program operated by the IHA.

4.1.3 Privileges are Facility or Program specific.

4.1.4 An application for the appointment of a Specialist or a Primary Care Practitioner who performs services within the Facilities or Programs operated by the IHA requires the completion of an impact analysis, based on Article 3.1.5 of the *Bylaws*, together with approval from the appropriate Senior Operational Administrator, or designate, that the impact can be addressed within the availability of current resources.

4.2 Application Procedure

The procedures for application and appointment to the Medical Staff are set out in Article 4.3 of the Bylaws. The credentialing and privileging process must be completed on or before the applicant's start date unless this requirement is specifically waived by the Senior Executive Medical Administrator.

4.3 Terms of Appointment

4.3.1 Appointments to the IHA Medical Staff are Health-Authority wide.

4.3.2 Privileges define the scope and location of a Practitioner's permit to practice in Facilities and Programs operated by the IHA.

4.3.3 Facility-specific Privileges convey no preferential status for Privileges in any other Facility or Program operated by the IHA.

4.3.4 A member of the Provisional, Active or Consulting Staff may apply for Privileges in another Facility or Program operated by the IHA. Additional Privileges may be granted by the Board after considering the recommendation of the HAMAC.

4.3.5 Each Practitioner shall be assigned to a Primary Department. The HAMAC shall consider requests for cross-appointment to other Departments on the advice of the Department Heads involved. Cross-appointments shall be based on the Practitioner's ability to fulfill membership responsibilities in each Department to which the Practitioner is assigned.

4.4 References

Specific references are required upon application for a Medical Staff appointment, as follows:

4.4.1 **Newly Qualified Medical Staff:**

i. One reference from the Dean or the Dean's representative of the medical school / professional program from which the applicant graduated;

ii. One reference from the applicant's residency, post-graduate or clinical Program Director;

iii. At least one reference from a teaching member of the facility where the applicant completed the majority of residency, post-graduate or clinical training.

4.4.2 **Established Medical Staff:**

i. One reference from the Senior Executive Medical Administrator of the last Facility where the applicant practised (or Senior Nursing Administrator, for Nurse Practitioners);

ii. At least two references from clinicians familiar with the current practice of the applicant. For physicians, references should be obtained from other physicians.

4.5 Procedural Privileges

Procedural Privileges are a permit to perform specific operations or procedures in designated Facilities and Programs operated by the IHA. Procedural Privileges are assessed using criteria from specialty-specific British Columbia Provincial Privileging Dictionaries and are granted by the Board on the recommendation of the HAMAC after a satisfactory review of the training, experience and competence of the Practitioner, the service needs of the IHA, and the requisite available resources in a specific Facility or Program operated by the IHA.

4.5.1 Physicians, dentists, midwives or nurse practitioners appointed to the Medical Staff may apply for procedural privileges. All procedural privileges require documentation of training and experience.

4.5.2 Certain procedural privileges may be defined by the HAMAC as "basic privileges" and may be granted automatically to all Medical Staff members, or specifically to members of certain specialties or sub-specialties.

4.5.3 The Department Head, or delegate, shall re-evaluate procedural Privileges during the reappointment process to confirm the Practitioner's maintenance of competence, the ongoing service needs of the IHA, and the requisite available resources in a specific Facility or Program operated by the IHA.

4.5.4 Procedural privileges may be granted to a physician, dentist, midwife or nurse practitioner based on adequate documentation provided by another Facility where that physician, dentist, midwife or nurse practitioner has held such privileges.

4.5.6 Where specific procedural privileges have been granted, the Board, in consultation with the HAMAC, on the advice of the appropriate

Department Head, may specify the frequency at which such a procedure must be performed in order for the physician, dentist, midwife or nurse practitioner to maintain these Privileges.

4.5.7 Procedural privileges require a special application in the following circumstances:

i. The introduction of new technology for which training has not previously been available to the specialty;

ii. A request for privileges outside the practitioner's specialty area;

iii. A request for specialty-specific privileges by a non-specialist practitioner.

4.6 **Enhanced Clinical Training:**

Physicians, Dentists, Midwives or Nurse Practitioners who apply to the IHA for the purposes of Enhanced Clinical Training (upgrading, remediation or mandated extra training) are not considered a member of the Medical Staff and are under the direct supervision of the Department Head or designate.

They shall be:

4.6.1 Licensed by the College of Physicians and Surgeons of BC, College of Oral Health Professionals of BC or College of Nurses and Midwives of BC;

4.6.2 Approved by the Department Head of the Department where upgrading will take place;

4.6.3 Approved and registered with IHA Medical Affairs;

4.6.4 Have qualifications commensurate with the level of training required (as determined by the Department Head or designate);

4.6.5 Have adequate approved professional liability insurance;

4.6.6 Carry out such duties that are assigned to them by the Department Head in which Department they have been approved for Enhanced Clinical Training. This does not include admission or discharge of patients;

4.6.7 Have a documented term for this Training.

4.7 **Observers**

4.7.1 Observers are practicing physicians, dentists, midwives, or nurse practitioners who wish to come to an IHA Facility to observe the provision of care or procedures related thereto. All observers, prior to their start date, shall be registered, as appropriate, with the College of Physicians and Surgeons of BC, College of Oral Health Professionals of BC or College of Nurses and Midwives of BC, as well as with the IHA Medical Affairs Department.

4.7.2 Observers other than those enrolled as students of health professions regulated by the Health Professions Act or Emergency Services Act of BC is not supported by the College of Physicians and Surgeons of BC (CPSBC).

4.8 Procedure to Address Letters of Intent Where No Medical Staff Vacancy Exists

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

4.8.1 An unsolicited letter of intent for membership on the Medical Staff does not constitute an application in accordance with Article 4.1.3 of the Bylaws.

4.8.2 Unsolicited letters of intent to apply for Medical Staff membership where a vacancy does not exist must be forwarded immediately to the Medical Affairs Department for appropriate review and management.

ARTICLE 5 — REVIEW PROCEDURES

Members of the Medical Staff should undergo routine reviews, during Reappointment and at regular intervals. This has the purpose to ensure quality of care, support professional development and assist in the development of individual improvement plans for Medical Staff.

5.1 Review at Reappointment

Members of the Medical Staff seeking re-appointment shall comply with the requirements outlined in Articles 4.4 and 4.5 of the Medical Staff Bylaws. The review shall include, at a minimum:

5.1.1 A review of the quality of the member's contribution to the IHA and Facility or Program;

5.1.2 Compliance with the IHA Bylaws, Rules, policies and procedures;

5.1.3 Quality and consistency of Health-Record documentation;

5.1.4 Completion of continuing-professional-development objectives, including anti-racism education and training;

5.1.5 Professional conduct, and;

5.1.6 The establishment and review of annual personal goals and objectives.

5.2 Comprehensive Review: Definition

A comprehensive review is intended for professional development and quality of care improvement. The review provides reviewees with feedback about their clinical practice. The review also includes a self-assessment and is designed to be both educational and for improvement. The comprehensive review shall be performed in compliance with *Section 51 of the Evidence Act*.

5.3 Comprehensive Review: Procedure

5.3.1 All members of the Medical Staff shall participate in a comprehensive review process prior to promotion from Provisional Staff to Active Staff and every three to five years thereafter.

5.3.2 The review shall be initiated by the Department Head or designate, or requested by the Medical Staff member.

5.3.3 The comprehensive review may include input from non-Medical Staff colleagues, Medical Staff colleagues, and members of clinical teams, who shall assess the Medical Staff member's performance in relation to clinical knowledge and skills, communication skills, and practice management. This may be performed with a standardized tool, such as the Medical Council of Canada (MCC) 360 tool.

5.3.4 50% of those providing input shall be selected by the Department Head or designate - the other 50% by the Medical Staff member.

5.4 **Comprehensive Review: Contents**

The Comprehensive Review may include the following:

5.4.1 Inpatient and outpatient clinical documentation including an assessment of the quality, accuracy, and timeliness of reports;

5.4.2 Current Curriculum Vitae;

5.4.3 Statement from the Medical Staff member outlining goals and objectives, including successes and challenges;

5.4.4 Patient incident reports, clinical complications and mortality events;

5.4.5 Staff and Medical Staff incident reports and complaints;

5.4.6 Continuing professional development, including the completion of Maintenance of Certification required by the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada, additional specific competence training completed since the last review, as well as any updates specific to departmental or program requirements;

5.4.7 Indigenous anti-racism education or training or indigenous cultural safety and humility education or training;

5.4.8 Procedural-privileges evaluation, including frequency of performance of specified procedures;

5.4.8 Direct observation of procedural and clinical assessment skills;

5.4.10 Interviews or communication with members of affiliated organizations and regulatory bodies;

5.4.11 Resource-utilization; and,

5.4.12 Patient or client feedback.

5.5 **Comprehensive Review: Review and Actions**

5.5.1 The results of the Medical Staff Member's Comprehensive Review shall be presented to the Department Head (or designate), Senior Executive Medical Administrator (or designate) and the Senior Executive Nursing Administrator (in the case of a nurse practitioner). The Department Head, or designate, shall review the results with the Medical Staff member and, where necessary, assist to develop a plan for a ongoing performance improvement.

5.5.2 The Medical Staff member shall acknowledge, in writing, receipt of the completed review, including planned follow-up discussion with the Department Head, or designate, and shall confirm agreement with any plan to address areas for improvement. The Medical Staff member shall complete and deliver this document to the Department Head, Senior Executive Medical Administrator or Senior Nursing Administrator (in the case of a Nurse Practitioner) within four (4) weeks of completion of the comprehensive review.

5.5.3 If the Medical Staff member will not acknowledge the results of the review in writing or refuses to agree to the requirements

outlined in the Comprehensive Review, the Department Head shall refer to the LMAC, RMAC or HAMAC for follow-up. The member has the right to appear before the MAC during the review process.

5.5.4 Final documentation of the Comprehensive Review shall include the report, any corrections of errors of fact, the Medical Staff Member's response, recommendations, implementation plan and reports on the implementation of recommendations. Discussions among the Department Head, Senior Executive Medical Administrator and Senior Executive Nursing Administrator (in the case of a nurse practitioner's) and the Medical Staff Member shall be summarized in writing and appended to the review.

5.5.5 Documentation of the Comprehensive Review process becomes and remains part of the Medical Staff Member's confidential personnel file.

5.5.6 The HAMAC and the Board shall be notified in writing of Comprehensive Review recommendations that require remedial action.

ARTICLE 6 – RESPONSIBILITY FOR PATIENT CARE

6.1 Admission, Discharge, and Transfer of Patients

6.1.1 Most Responsible Practitioner (MRP)

Every patient shall be admitted by a member of the Medical Staff who has admitting privileges and who has primary responsibility for the management and coordination of care for the patient. This Practitioner shall be identified as the Most Responsible Practitioner (MRP). The MRP is established on the basis of whose scope of practice is best suited to treat the most responsible diagnosis at the time of admission.

6.1.1.1 The MRP is determined either prior to the admission for planned surgical admissions or subspecialty interventions and treatment, or at the time a decision to admit is made in the Emergency Department (ED).

6.1.1.2 The MRP works collaboratively with a team to deliver care and treatment to the patient.

6.1.1.3 If the patient's medical condition warrants consultation with other members of the Medical Staff, the MRP coordinates and facilitates these consultations.

6.1.1.4 During a patient's admission, the role of the MRP may be transferred, based upon the changing acuity and nature of the patient's medical condition.

6.1.1.5 Further, the MRP shall:

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

ii. Complete and document a full assessment for admission, including a full history, physical examination and orders for ongoing care;

iii. Work collaboratively with healthcare team members, including in the development of a Best Possible Medication History (BPMH), complete medication reconciliation and order appropriate medications;

iv. Oversee the patient's care, either directly or through an on-call group;

v. Provide daily ongoing direct care documented in daily progress notes for all acute-care patients, or provide direct care documented in weekly progress notes for alternate-level of-care (ALC) patients;

vi. Communicate with the patient, the patient's family and the patient's care-team members, including the patient's primary-care provider, regarding medical conditions, tests and planned consultations. This information shall be shared with other parties at the patient's written request and consent, or as required by law;

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

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

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

6.1.2 Pre-Admission Requirements

The admitting member of the Medical Staff (MRP) is responsible for pre-admission requirements for elective patients and residents, which include the patient's medical history, physical examination, diagnosis, laboratory investigations, appropriate consultations, special tests and documentation of special precautions, patient consents and directives.

6.1.3 Admission

6.1.3.1. Patients and residents shall only be admitted to the facility for investigation or treatment upon the order of a member of the Medical Staff.

6.1.3.2 Where two (2) or more Medical Staff are involved with the care of the patient, one (1) Medical Staff must be identified as the MRP.

6.1.3.3 Unless properly indicated on the orders, the admitting member of the Medical Staff shall be deemed to be the MRP.

6.1.3.4 The MRP, or designate, or Resident / Fellow acting on the advice of the MRP or designate shall request admission of the patient from the Admitting Department and provide the admitting diagnosis, and an outline of the investigations/treatment for which hospitalization is required.

6.1.3.5 The Admitting Department shall inform the admitting member of the Medical Staff of the hour for elective admissions.

6.1.3.6 For emergency admissions, the MRP or designate, or Resident / Fellow acting on the advice of the MRP or designate will certify the severity of the patient's condition and the circumstances necessitating special consideration.

6.1.3.7 The MRP or designate, or Resident / Fellow acting on the advice of the MRP or designate shall note special precautions regarding the care of the patient on the patient's health record.

6.1.3.8 All patients for surgery must have a current history and physical examination recorded on the patient/resident health record prior to surgery.

6.1.3.9 All patients and residents must have a record of history and physical examination within twenty-four (24) hours of admission.

6.1.3.10 All patients and residents must have a goals of care discussion (or discussed with a representative decision maker) and a documented Medical Orders for Scope of Treatment (MOST) completed within twenty-four (24) hours of admission.

6.1.3.11 If, at the time prior to accepting MRP but, where possible, after assessing the patient in person, the Medical Staff member does not believe he/she is the most appropriate Practitioner for the role of MRP, the Medical Staff member shall liaise directly with an alternate service and with the Admitting Department regarding the most appropriate Medical Staff member or service to assume the MRP role.

6.1.3.12 Where an admission disagreement exists, an Admitting Department shall contact the Head(s) of the Division(s) or Department(s) to which the Medical Staff members in dispute are assigned. If this is not possible or unsuccessful, the Admitting Department shall contact the Senior Facility Medical Administrator (or designate), who shall make an immediate service assignment. At the earliest opportunity during regular working hours the incident shall be reviewed by the appropriate Department or Division Head(s).

6.1.4 Admissions for Treatments by Other Regulated Health Professionals

For patients admitted for treatment by other regulated health professionals, an eligible member of the Medical Staff shall be the MRP.

6.1.5 Discharge

6.1.5.1 Discharge of patients from the Hospital may be authorized only by the MRP or designate, or by a Resident / Fellow acting on the advice of the MRP or designate.

6.1.5.2 Discharge planning should begin at the time of admission. The MRP or designate is responsible for identifying the expected date of discharge (EDD) within twenty-four (24) hours of admission on the patient's chart and updating the EDD regularly throughout the stay.

6.1.5.3 The MRP or designate shall, when possible, indicate the planned discharge on the day prior to discharge.

6.1.5.4 Any alterations to the discharge plan following the discharge order must be documented, including new discharge orders.

6.1.5.5 Should a patient, or an incapacitated patient's substitute decision maker, or legal guardian or committee demand that the patient be allowed to leave the Hospital against the MRP or designate's advice, the patient or his substitute decision maker, legal guardian or committee shall be asked to sign a release on the prescribed form. Refusal to sign this release should be noted in the medical record.

6.1.5.6 Patients who have been absent without a pass for greater than six (6) hours of the end of an official pass period are deemed discharged AMA. Psychiatric patients are excluded from this rule.

6.1.5.7 A discharge summary shall be dictated on discharge or within one working day of a patient's discharge. Changes in status, medications and other issues significant to the immediate follow-up shall be communicated at the time of discharge if a discharge summary is not immediately available.

6.1.6 Readmission

All readmissions require a full history and physical. For unplanned readmissions, special attention should be paid to any contributing factors.

6.2 Medical Consultations

6.2.1 In-Patient Consultation Process

6.2.1.1 Consultation shall be initiated by the MRP or designate or other member of the Medical Staff involved in the care of the patient. Direct communication between referring and consulting providers is the responsibility of members of the Medical Staff. Nursing staff are not expected to be involved in the consultation request. The urgency in response for consultation should be conveyed at initiation.

6.2.1.2 In the case of an urgent or emergent situation, if the MRP is engaged in ongoing care, another healthcare professional may request the consultation.

6.2.1.3 Consultation shall be held:

6.2.1.3.1 At the request of the MRP or designate.

6.2.1.3.2 At the request of the Department Head, Associate Department Head, Division Head, Local Medical Director or the Senior Medical Director.

6.2.1.3.3 In other situations as determined from time to time by the Department Head, Division Head, Local Medical Director or the Senior Medical Director.

6.2.1.3.4 The MRP shall obtain consultation when required by Law, or as directed in the IHA's Organizational Policy or Procedure.

6.2.1.4 The consultant will make every effort to respond in a timely fashion, in accordance with the clinical condition of the patient, and within 48 hours in all cases. If the consultation cannot be completed within 48 hours, the consultant must notify the referring practitioner.

6.2.2 Consultation Record

The consultant member of Medical Staff shall examine the patient and document the findings, opinions, and recommendations on the clinical record. When a member of the Resident / Fellow performs the consultation, the findings, opinion and recommendations may be recorded on the consultation record or dictated. The consultant physician must confirm agreement by signing the plan outlined in the consultation record or notes completed by the member of the Resident / Fellow or confirming in the notes that they agree with the Resident / Fellow dictated consult record or dictation of a formal consult.

6.3 Emergency Care

In an emergency, any member of the Medical Staff is expected to provide and document medical care until a patient's MRP or designate can assume responsibility.

6.4 Post-Operative Care

6.4.1 The MRP or designate is responsible for the post-operative care and completion of the health record of the patient unless otherwise indicated on the orders of the patient's health record and confirmed, in writing, by the member of the Medical Staff assuming this responsibility.

6.4.2 Where a post-operative patient has medical co-morbidities requiring management by another Medical Staff member, the parameters of that care shall be clearly described in the Health Record.

6.4.3 For patients admitted for dental surgery, the attending Dentist shall be responsible for the patient's dental surgery and dental care only. An alternate Medical Staff member must be identified who shall attend the patient for any required medical care.

6.5 Ambulatory Care and Outpatient Facilities or Programs

6.5.1 Only Medical Staff members with appropriate Privileges shall act as MRP for patients who require medical or mental health treatment in Ambulatory Care and Outpatient Facilities and Programs operated by the IHA.

6.5.2 A Medical Staff member wishing to treat a patient in an Ambulatory and Outpatient Facility or Program shall be designated as the MRP and shall maintain responsibility for all subsequent care ordered and carried out in the Facility or Program, whether or not the Practitioner is physically present at the site. This excludes routine out-patient laboratory testing and medical imaging appointments.

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

6.6 Interfacility Transfer of Care

6.6.1 When a patient is to be transferred to another facility, the MRP shall ensure that there is an appropriately qualified Practitioner available at the receiving site who is fully informed about the patient's condition and has agreed to assume responsibility for the patient's care. Acknowledgment of this conversation and acceptance of the transfer of care shall be documented in the Health Record by the sending and receiving practitioners before the transfer shall occur. The MRP shall identify to the staff member arranging the transfer all relevant documentation from the patient Health Record to be sent to the receiving Facility. The transfer of care must be documented in the Health Record.

6.6.2 Where a patient is transferred to another Facility or Program for administrative rather than medical reasons (for example, lack of available beds at the sending facility or program), the MRP, if not assuming the MRP role at the new Facility or Program, shall speak to the receiving Practitioner directly to provide information regarding the plan of care. Acknowledgment of this conversation and acceptance of the transfer of care shall be documented in the Health Record by the sending and receiving practitioners before the transfer shall occur. The Administrator-on-Call at the receiving site shall coordinate this conversation to ensure safe and timely access to necessary services. The transfer of care must be documented in the Health Record.

6.6.3 At a minimum, a transfer note, but preferably a discharge summary completed by the sending practitioner, shall accompany the patient upon transfer either as a legible, signed and dated hardcopy delivered with the patient or, where both sites have deployed the EHR, by dictation or electronic entry into the EHR.

6.6.4 A medication reconciliation should be performed by the sending and receiving MRP.

6.6.5 Transfer to a Higher-Level-of-Care Facility or Program

6.6.5.1 When, in the opinion of the MRP, clinical resources are not available for the appropriate and safe care of the patient, the practitioner shall initiate a process to transfer the patient to a more suitable Facility.

6.6.5.2 The practitioner shall be responsible to identify the level of resources needed to provide safe care and provide relevant medical information in keeping with clinical policies and procedures where they apply.

6.6.5.3 The logistics of the transfer of the patient to a Facility with adequate resources shall not be the responsibility of the MRP, unless in exceptional circumstances and where the involvement of the MRP does not compromise patient care at the sending site.

6.6.5.4 No tertiary or regional service area hospital within IH may refuse transfer of a Life Limb Threatened Organ (LLTO) and psychiatric behavioural emergency patient where the standard of care or treatment required is available at the hospital, regardless of in-patient bed capacity. This in compliance with IH Policy (AH0300).

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

6.6.6.1 Repatriation back to the original referring Facility or Program shall comply with IH Policy (AH3600)

6.6.6.2 The logistics of the transfer of the patient to a Facility with adequate resources shall not be the responsibility of the MRP, unless in exceptional circumstances and where the involvement of the MRP does not compromise patient care at the sending site.

6.6.7 Transfer due to a Health Facility Evacuation Order

6.6.7.1 In the situation of a Health Facility Evacuation Order, the MRP will undertake all efforts to identify an appropriate receiving MRP and fulfill all requirements of s. 5.6.1.

6.6.7.2 The logistics of the transfer of the patient to a Facility with adequate resources shall not be the responsibility of the MRP, unless in exceptional circumstances and where the involvement of the MRP does not compromise patient care at the sending site.

6.7 **Responsibility for Provision of Medical Care**

6.7.1 Continuous Care

6.7.1.1 Each member of the Medical Staff has a duty to comply with the Bylaws and these Rules including the responsibility to ensure that every patient is continuously under the care of the appropriate and available member of the Medical Staff. The MRP or delegate shall not withdraw services, whatever the reason, prior to the patient's discharge without proper transfer of the patient's medical care.

6.7.1.2 Any member of the Medical Staff who is away from practice or who has transferred responsibility of care to another member of the Medical Staff shall indicate the name of the member of the Medical Staff assuming responsibility for the patient's care on the order sheet of the patient's health record. The receiving member of the Medical Staff shall acknowledge transfer in writing on the order sheet.

6.7.1.3 If the member of the Medical Staff wishes to withdraw from involvement in a patient's care when services are still required, they shall inform the patient and arrange for another member of the Medical Staff of appropriate qualification to assume responsibility for the care of the patient and document that on the order sheet of the patient's health record.

6.7.1.4 In the event that an MRP or delegate fails to attend upon a patient for whom he/she is responsible, the Department Head concerned shall designate an appropriate member of the Medical Staff to be responsible for the patient (MRP) and shall report the matter in writing to the Senior Medical Director, and HAMAC.

6.7.1.5 A patient, deemed to have capacity, has the right to request a change in any member of the Medical Staff involved in their care. The MRP or other member of the Medical Staff shall cooperate in transferring responsibility for care to an appropriate new member of the Medical Staff acceptable to the patient. If an acceptable alternative cannot be found, the Department Head shall appoint a member of the Medical Staff who will continue to provide care to the patient until such responsibility is transferred. The transfer of care must be documented on the order sheet of the patient's health record.

6.7.2 Daily Care

6.7.2.1 A patient in acute care must be seen or reviewed on the ward by the MRP or delegate, at least daily, or more frequently as required.

6.7.2.2 Whenever the MRP or delegate sees a patient, a progress note shall be written. The note shall provide sufficient detail to allow the formulation of a reasonable picture of the patient's clinical status at the time of observation and shall reflect the involvement of the MRP or delegate in the patient's care.

6.7.3 On-Call Coverage

6.7.3.1 All members of the Medical Staff shall participate in departmental on-call rosters, except in special circumstances, approved by the Department Head and Senior Medical Director.

6.7.3.2 Each Department and/or Division shall ensure a rotation of members to provide emergency coverage and shall routinely provide a list of such rotation to the Emergency Departments and medical administration. The list must be updated as changes occur. Unless specifically excluded by the HAMAC and subsequently approved by the Board, all Departments and Divisions are required to provide continuous on-call coverage to manage:

6.7.3.2.1 Emergency-Department (ED) patients who require urgent consultation or in-patient admission; and

6.7.3.2.2 Patients already admitted to a Facility whose condition necessitates urgent intervention or consultation by a Medical Staff member other than the MRP.

6.7.3.3 The Department Head or delegate, if applicable, shall assign each member to a reasonable on-call schedule. Unless specifically excluded by the Board, on advice from the HAMAC and the applicable Department Head, all Department members are required to contribute equitably in fulfilling the on-call responsibilities of the Department.

6.7.3.4 On-call members of the Medical Staff will be expected to maintain acceptable levels of availability. Those Departments and Divisions, which deal with life-threatening emergencies, shall maintain timely Medical Staff availability.

6.7.3.5 Groups of practitioners with a similar scope of practice may organize in call-groups to share the requirements of their patients' care. These practitioners shall create an on-call rota to ensure 24-hour coverage for the group's in-patients in a manner acceptable to their Department or Division Head and the Senior Executive Medical Administrator.

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

6.7.3.7 Where community size or practitioner numbers necessitates a call group whose practitioners have different skillsets, the call-group members shall establish a group on-call strategy to ensure all medical needs of the patient are met.

6.7.3.8 Where call-group members practice in different communities, the members may establish a cross-community on-call rota, provided a clinical service-delivery model is established to ensure patients have local access to an on-call member as required. A cross-community on-call rota requires HAMAC and Department Head approval, after the Department Head and applicable Division Head, if any, have been consulted.

6.7.3.9 The method of practitioner compensation, whether through fee-for-service, alternate payment contract or sessional payment, has no bearing on the individual or collective requirement to provide continuous on-call coverage.

6.7.3.10 On-call requirements, terms and conditions may be governed through contractual arrangements between the IHA and individual members of the Medical Staff. The availability, or lack thereof, of a Medical On-Call Availability Program (MOCAP) contract has no bearing on the individual or collective requirement to ensure continuous on-call coverage for admitted patients.

6.7.4 On-call Scheduling

The establishment of an on-call schedule shall be mandatory for each call group and shall:

6.7.4.1 Provide a Medical Staff member available to assess and treat a patient(s) at all times;

6.7.4.2 Be kept current at all times;

6.7.4.3 Identify the Medical Staff member by name, including up-to-date expedited contact information;

6.7.4.4 Identify the practitioner responsible for maintaining the on-call list, including contact information;

6.7.4.5 Be made available in a manner, time and format acceptable to the IHA in order to distribute it to necessary recipients;

6.7.4.6 Be submitted by the Department Head, Division Head or designate as soon as possible, but at least 30 days prior to the date on-call is to be provided. Changes to the call schedule shall be clearly distributed in advance to all necessary recipients;

6.7.4.7 In the event of an unresolved dispute concerning on-call frequency, the matter shall be reviewed and resolved by an IHA LMAC, RMAC or, ultimately, the HAMAC.

6.7.5 On-Call Exemptions

6.7.5.1 A Practitioner may be exempted from providing on-call coverage only when continuous coverage can still be assured by the Department.

6.7.5.2 In an urgent situation or in an emergency, the Senior Executive Medical Administrator may grant a temporary exemption from providing on-call coverage. In this circumstance, the Department Head, Division Head or designate shall exercise all means available to find a replacement.

6.7.5.3 The Department Head, in consultation with the relevant Division Heads and Department members, shall establish written criteria for requesting an exemption of its members from on-call responsibilities. A Department or Division shall only request an exemption for a member if the other Department or Division members are prepared to fulfil and sustain that member's on-call obligations.

6.7.5.4 The Department Head shall provide the HAMAC with reasons for a proposed exemption, any changes to an already-existing exemption and the potential consequences of an exemption, which shall assist the HAMAC to provide an appropriate recommendation to the Board.

6.8 Scheduled Treatments and Procedures

This article applies to all medical and surgical procedures or treatments requiring pre-booking according to IHA policy and procedure.

6.8.1 Booking

6.8.1.1 Medical Staff who book patients for surgical procedures shall comply fully and fairly with operating room and ambulatory care booking codes.

6.8.1.2 If a scheduled treatment or procedure is cancelled for administrative reasons, administrative staff shall be responsible for rebooking the procedures in consultation with the Medical Staff member and for notification of the patient and the primary care provider.

6.8.2 Requirements in Operating Rooms

6.8.2.1 The Medical Staff performing the procedure (the "surgeon") shall be the MRP during the operative and peri-operative periods, and for subsequent post-operative management of the patient.

6.8.2.2 All major surgery will be performed with the assistance of a second physician or a trained assistant.

6.8.3.3 Prior to the patient entering the operating room for any surgical procedure, the surgeon or delegate shall personally discuss with the patient the procedure and site to be operated upon and mark the site in an approved manner as per IHA's Policy.

6.8.3.4 Upon the patient entering the operating room, a pre-operative "timeout" including the surgeon or delegate, anesthesiologist, and all nursing staff present shall take place to ensure correct patient, procedure, and site. The occurrence of the timeout shall be recorded in the operative record. The surgeon or delegate is ultimately responsible for this process taking place.

6.8.3.5 Before leaving the operating room, the Medical Staff member shall ensure that a pathology requisition for examination of all tissues or other removed material has been completed. All tissues or materials must be sent to the Pathology Department.

6.8.3 Requirements for Treatments and Procedures Performed Outside Operating Rooms

6.8.3.1 The Medical Staff performing the procedure (the "surgeon") shall be the MRP during the operative and peri-operative periods, and for subsequent post-operative management of the patient.

6.8.3.2 Prior to the patient entering the procedure room for any surgical procedure, the surgeon or delegate shall personally discuss with the patient the procedure and site to be operated upon and mark the site in an approved manner as per IHA's Policy.

6.8.3.3 Before leaving the procedure room, the Medical Staff member shall ensure that a pathology requisition for examination of all tissues or other removed material has been completed. All tissues or materials must be sent to the Pathology Department.

6.9 **Medical Staff Orders**

6.9.1 Documentation

6.9.1.1 All orders and documentation by a Medical Staff member must be entered into the EHR by CPOE, dictation or electronic entry in all IHA Facilities where the EHR is in use.

6.9.1.2 Where CPOE is not deployed, orders written on an IHA-approved order form may be faxed and implemented, provided they are signed by a member of the Medical Staff.

6.9.2 Orders for Treatment

All orders for treatment shall have the name printed and be legibly written, dated, timed, numbered (with the professional body's license number), and signed by a registered and licensed member of a Regulatory Body, as defined in the *Health Professions Act*, in accordance with the standards and scope-of-practice for members of that Regulatory Body. Medication orders will follow acceptable standard with respect to legibility, use of abbreviations (avoidance of 'Do Not Use Abbreviations'), and adherence to formulary policies.

Failure to comply with 6.9.2 will initiate the following:

6.9.2.1 In the first instance, a letter to the member of the Medical Staff detailing the non-compliance. A copy of this letter will be forwarded to the appropriate Department / Division Head.

6.9.2.2 Medical Staff receiving a second letter will receive a warning from the Department Head.

6.9.2.3 Medical Staff receiving a third letter for failure to comply with 6.9.2 will need to complete the online Safe Prescribing module and meet with the Department Head and the Senior Medical Director. The meeting will be documented and a summary will be added to his/her personnel file.

6.9.2.4 Medical Staff receiving a fourth letter may be automatically suspended from the Medical Staff. This notice will be forwarded to the College of Physicians and Surgeons as required by the Health Professions Act.

6.9.3 Medication Orders

6.9.3.1 Medical Staff members prescribing medication shall comply with the *Narcotic Control Act* and other legislation pertaining to the prescription and use of drugs.

6.9.3.2 Where the HAMAC has approved standards, policies or guidelines for the use of certain drugs, these drugs shall be distributed by the Director of Pharmacy in accordance with the HAMAC's directions.

6.9.3.3 Medical Staff members who knowingly order medication in contradistinction to established IHA standards, policies or guidelines shall accept full accountability for those orders.

6.9.3.4 In accordance with IHA policy, all medications ordered by a Medical Staff member that are not listed in the IHA Drug Formulary shall be reviewed by pharmacy staff, who shall make recommendations for appropriate substitutions.

6.9.3.5 Investigational drugs and therapies that are requested in an urgent situation may be used only with the written approval of an Executive Medical Director, the Senior Facility Medical Administrator or the Pharmacy Director. These drugs must be ordered by the MRP or a specialist who has been consulted by the MRP.

6.9.4 Pre-Printed Orders

6.9.4.1 A Department, Program or Network may sponsor and establish order sets for patients under the care of members of that Department, Program or Network. The appropriate subcommittee of the HAMAC approves pre-printed order sets and shall arrange for order set review at least bi-annually.

6.9.4.2 Order sets will be developed to be applicable for use at all IH Facilities.

6.9.4.3 Order sets shall comply with the IHA's safe-prescribing guidelines and the standards set by the Medical Staff member's Regulatory Body.

6.9.4.4 The Medical Staff member shall sign order sets for each patient.

6.9.5 Verbal Orders

6.9.5.1 Under normal circumstances, the Medical Staff Member will enter orders in the patient's chart, or EMR. If necessary, a Medical Staff Member may give verbal or telephone orders for treatment to a registered nurse, a licensed practical nurse, a respiratory therapist or a perfusionist, or a pharmacist, who shall transcribe the order onto the chart under the Medical Staff Member's name per the writer's name.

6.9.5.2 The nurse, licensed practical nurse, respiratory therapist, perfusionist, or pharmacist will read the order back to the member of the Medical Staff who will confirm that it is correct prior to it being carried out. Such orders shall be countersigned by the Medical Staff member or designate at the earliest opportunity, but no later than 24 hours.

6.9.5.3 At non-CPOE sites, orders provided by telephone shall be written over the name of the ordering Medical Staff member and signed by the person to whom they are dictated. At CPOE sites, upon order entry, orders shall be notated as "verbal orders" on behalf of the ordering Medical Staff member and shall be assigned to that member for electronic co-signature. These orders shall be counter-signed by the ordering Medical Staff member as soon as possible, but no later than 24 hours after the orders are given.

6.9.6 Resident / Fellow Orders

Resident / Fellow may write orders and prescribe controlled drugs according to IHA guidelines and any Affiliation Agreement.

6.9.7 Student Orders

When a student has been assigned to a patient's care for teaching, the student may write orders as per an Affiliation Agreement. In the cases of orders for therapeutic drugs or invasive procedures or investigations, the MRP or delegate shall, except in an emergency, discuss such orders with the student and approve them. The MRP or delegate must countersign the order at the earliest opportunity, but no later than 24 hours.

6.10 **Health Records**

Health Records are those electronic or paper documents compiled by the Medical Staff and other clinical staff of the IHA to document care provided to patients, residents and clients. Health Records may be Facility-based or Community-based. The term Health Records, as described in the Bylaws, Rules and Policies, shall mean Facility-based records. Community-based records shall be referred to specifically as such. A timely, comprehensive and complete Health Record is essential to ensure that patients, clients and residents receive the best care possible in Facilities operated by the IHA, as well as in the community after they are discharged from IHA Facilities.

All IHA Medical Staff members shall obtain and maintain access to the IHA EHR.

The MRP or delegate shall be responsible for the completion of the medical component of the health record for each patient. The record shall include the following items, where applicable:

6.10.1 Admission History

6.10.1.1 Except in extreme emergency, the MRP or delegate shall ensure that every patient admitted to a IHA facility has an adequate clinical history, physical examination and provisional diagnosis recorded in the health record within twenty-four (24) hours after admission and prior to every delivery or operation.

6.10.1.2 The admission documentation shall include:

a) presenting complaint
b) history of presenting complaint
c) allergies and sensitivities
d) medications
e) significant past medical, social and family history
f) review of systems including any deviations from normal
g) physical examination
h) results of pertinent diagnostic investigations
i) active problem list
j) management plan with an estimated length of stay
k) admitting diagnosis, or differential diagnosis if the diagnosis is unclear at the time of admission
h) admission orders including, at a minimum, diet, activity level, frequency of vital-signs measurement, required investigations and diagnostic tests, and any treatment to be initiated.

6.10.2 Progress Notes

The progress notes shall:

6.10.2.1 Describe a treatment plan; changes in the patient's condition; response to treatment; reasons for change of treatment, and outcome of treatment.

6.10.2.2 Be documented as frequently as the patient's condition warrants.

6.10.2.3 For written progress notes, be legible, dated, timed, and signed.

6.10.3 Operative Records

6.10.3.1 In elective or urgent surgical cases a documented history and physical examination report and the signed operation consent shall be submitted to the booking clerk prior to the booking of the operation.

6.10.3.2 If such history and physical examination are not recorded before the time slated for operation the operation shall be canceled unless the MRP or delegate states in writing that such delay would result in mortality or significant morbidity. The appropriate surgical management committee shall review all such cases.

6.10.3.3 An operative report is required for all invasive procedures except those excluded by the HAMAC. The report shall be dictated or electronically entered within 24 hours of completion of an operation or other high-risk procedure, but preferably immediately post-procedure. If the operative report is not placed in the Health Record immediately after dictation, then a progress note shall be entered in the Health Record immediately after the procedure.

6.10.3.4 The operative report shall contain, at a minimum:

a) the patient's name and Health Record number;
b) the name of the primary surgeon and assistant(s);
c) the names of practitioners who should receive a copy of the report;
d) date and time of admission;
e) date of procedure;
f) pre-operative and post-operative diagnosis;
g) proposed procedure(s) and indications;
h) operative procedure(s) performed;
i) operative complications, if any;
j) the patient's condition before, during and immediately after the operation;
k) estimated blood loss;

l) specimens removed and their disposition (for example, "sent to pathology").

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

6.10.3.6 In the exception of a patient requiring immediate surgical intervention, prior to any anaesthetic procedure, the anaesthesiologist must record a pre-anaesthetic assessment on an appropriate record. The anaesthetic record must be completed before the patient leaves the recovery room.

6.10.4 Prenatal Record

The prenatal record is considered to be an integral part of the health record and will constitute a history and physical, and the information will be submitted in accordance with the B.C. Reproductive Care Program guidelines.

6.10.5 Discharge Record

A discharge record is a critical record of information to ensure quality of patient care. Incomplete or inaccurate discharge summaries may potentially compromise ongoing patient care and impair the ability of the Health Records Department to extract vital data.

6.10.5.1 The MRP or Medical Staff member on-call shall provide a discharge order and complete a discharge summary using a HAMAC-approved discharge template. The discharge summary shall be completed electronically in Facilities where the EHR is in use. Discharge summaries shall be completed through the IHA transcription service or on an approved written template for those Facilities employing a paper Health Record.

6.10.5.2 All patients shall have their discharge order written on paper, or electronically if the Facility uses CPOE, as early as possible on the day of discharge. For expedited planning purposes, the MRP shall note the estimated date of discharge (EDD) daily in the patient's Health Record except for non-ALC patients.

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

a) an uncomplicated daycare or short-stay surgery or procedure;
b) an uncomplicated obstetrical delivery;
c) an uncomplicated neonatal admission; or

d) a short admission where the HAMAC has approved an abbreviated discharge documentation process.

6.10.5.4 For uncomplicated obstetrical admissions, the British Columbia (BC) Antenatal Record Part 1 and 2, or electronic equivalent for Facilities using an EHR, shall become an integral part of the patient record. The BC Labour and Birth Summary Record or electronic equivalent, together with the BC Newborn Record Part 1 and 2 shall be completed and placed in the Health Record by the MRP and shall form the discharge summary in uncomplicated deliveries.

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

6.10.5.6 To ensure continuity of care and patient safety, the discharge summary should be dictated, or electronically transcribed in those Facilities using the EHR, at the time of discharge but must be completed within seven (7) days of the discharge date.

6.10.5.7 A discharge summary shall include:

a) a single most responsible discharge diagnosis
b) other relevant diagnoses and co-morbidities
c) past medical history
d) surgical or interventional procedures performed
e) unexpected occurrences, including new post-admission diagnoses, that impacted the patient's length of stay, complexity, clinical care or treatment
f) a summary of the patient's course in hospital
g) the patient's condition at discharge
h) the disposition of the patient, whether to another hospital, home or to a community facility
i) a list of medications administered in-hospital; and a list of those prescribed or continued at discharge, including dosage and frequency
j) discharge instructions, including follow-up instructions and a specific post-discharge plan provided to the patient, the patient's regular medical Practitioner, and any caregivers reasonably expected to require this information for ongoing care-delivery. These instructions should include a list of all appointments made with consultants, any pending outpatient investigations, outstanding tests, and any home and community-care support arranged or needing to be arranged.

6.10.6 Completion of Health Records

6.10.6.1 All Health Records shall be completed and validated by all Medical Staff members involved in the patient's care, in compliance with the IHA Health Information Management (HIM) policies. All Medical Staff members must comply with IHA HIM clinical documentation requirements.

6.10.6.2 The MRP or delegate is responsible for notifying Health Records and the respective Division or Department Head of planned absences prior to their occurrence. Following notification, the MRP or delegate will be responsible for the completion of outstanding health records within twelve (12) days of return from such leave or absence.

6.10.6.3 If the MRP is no longer available to sign orders, the Health Record shall be completed by the appropriate Department or Division Head.

6.10.6.4 Where the EHR has been implemented in an IHA Facility or Program, Medical Staff members shall enter all required documentation and orders into the IHA EHR. Written orders or paper documentation are not accepted for Health-Record completion in these Facilities or Programs.

6.10.6.5 Draft electronic and transcribed reports shall be corrected and finalized within 72 hours of report generation.

6.10.6.6 Reports will not be distributed until they are corrected and finalized.

6.10.6.7 Each Medical Staff member shall have at least one report-distribution method identified and activated in the EHR.

6.10.6.8 The patient's Health Record should be completed at the time of discharge but must be completed within seven (7) days of discharge from the Facility.

6.10.6.9 If the patient's Health Record is not completed at the time of discharge, the following policy shall apply:

6.10.6.9.1 The Medical Staff member shall be notified of incomplete charts within fourteen (14) days and every seven (7) days thereafter.

6.10.6.9.2 Following the first notification, the Medical Staff member shall complete the charts within fourteen (14) days.

6.10.6.9.3 Failure to comply with 6.10.6.9.2 will result in the IHA Health Records Department sending two further notifications, each seven (7) days apart.

6.10.6.9.4 Failure to comply with 6.10.6.9.3 will initiate a letter to the member of the Medical Staff automatically suspending hospital privileges, sent from the Senior Facility Medical Administrator. A copy of this letter will be forwarded to the appropriate Department Head. The MRP or delegate must arrange transfer of care of patients to an appropriate member of the Medical Staff.

6.10.6.9.5 The suspension of privileges is automatically cancelled once the outstanding Health Records are complete.

6.10.6.9.6 Medical Staff members suspended three or more times in a consecutive 12-month period shall attend an interview with the appropriate Department Head or designate to plan remedial action. If administrative suspensions continue following this meeting, the member shall be required to appear before an LMAC, RMAC or ultimately the HAMAC, which shall impose an immediate 30-day suspension of privileges and may recommend disciplinary action up to and including permanent revocation of Medical Staff Privileges.

6.10.6.9.7 Locum Tenens Medical Staff members shall complete the Health Records of all patients for whom they have been MRP, performed procedures or entered orders during the locum period. The Medical Staff member whom the locum replaced shall be responsible to complete any Health Records left incomplete by the Locum Tenens.

6.10.6.9.8 Medical Staff leaving practice, including for retirement, relocation or removal from the Medical Staff, must complete all Health Records available on or before the effective date of the termination of IHA Medical Staff privileges.

6.10.7 Ownership and Access

6.10.7.1 Health records are the property of IHA and are not to be removed from IHA except as ordered by the courts or with consent of IHA.

6.10.7.2 Access to and copies of the health record or information contained therein is governed by policies of IHA. Breach of these policies would be considered a breach of ethical conduct.

6.10.7.3 Medical Staff who have private offices within IHA retain ownership of their office records as described by the B.C. College of Physicians and Surgeons.

6.10.8 Storage of Records

Health Records shall be maintained and stored by the IHA Health Information Management (HIM) services, unless otherwise approved by the CEO or designate.

6.11 **Informed Consent**

6.11.1 Informed Valid Consent

Examination, treatment, procedure or operation, and the transfusion of blood or blood products other than in the case of emergency health care, may not be carried out on any patient in IHA unless the informed valid consent of the patient or the substitute decision maker has been obtained, as per appropriate IHA policy and governing legislation.

6.11.2 Medical Staff Responsibility for Obtaining Consent

The member of the Medical Staff responsible for performing a procedure is responsible for obtaining valid informed consent prior to carrying out that procedure and will not proceed until the appropriate signed IHA consent form has been placed on the patient health record.

6.12 **Organ Donation and Retrieval**

With the establishment of a Provincial Donor Registry and the Human Tissue Gift Act, amendments to this rule concerning the process for organ donation and removal should be updated regularly to reflect provincial policy.

6.12.1 Privileges for Organ Retrieval

The Senior Executive Medical Administrator or delegate may grant temporary privileges to eligible health care professionals as designated under the *Health Professions Act* for situations such as organ retrieval.

6.12.2 Consent

6.12.2.1 Consent for solid organ donation shall be obtained from the authorized individual set out in the Human Tissue Gift Act after the declaration of neurological death, on the appropriate consent form by a member of the Medical Staff or a Resident / Fellow. Telephone or verbal consent requires two (2) witnesses (nurse or member of the Medical Staff).

6.12.2.2 In the event of eye or non-solid organ tissue donation only, consent shall be obtained from the authorized individual after cardiac death, by a member of nursing staff, Medical Staff or a Resident / Fellow, or an employee of the Eye Bank or the Tissue Bank of British Columbia. The member of the Medical Staff and the nurse collaboratively decide who is most appropriate to obtain consent for eye donation. The Eye Bank requires two witnesses (nurse or member of the Medical Staff) for telephone or verbal consent.

6.12.3 Determination of Death

6.12.3.1 In the declaration of neurological death for organ donation, consultation shall be held with a neurosurgeon or neurologist, or the Medical Staff member representing the highest level of neurological skills available at the health care facility.

6.12.3.2 In the case of solid organ donation, the criteria for the diagnosis of neurological death published by the Canadian Congress of Neurological Sciences (1986), and available from the Organ Retrieval Team, will be followed in accordance with Part 2 Section 7 of the Human Tissue Gift Act.

6.12.4 Physiological Maintenance of Organ Donor

6.12.4.1 In the event of solid organ donation, responsibility for the physiological maintenance of the solid organ donor after the declaration of neurological death may be transferred, at the discretion of the MRP or delegate, to a member of the Organ Retrieval Team.

6.12.4.2 In the case of solid organ donation, after the declaration of neurological deathcand in the event that the MRP or delegate has transferred responsibility of care to the Organ Retrieval Team, standing orders (available from the organ retrieval team) will be followed. Any deviation from standing orders protocol will be discussed in consultation with the MRP or delegate.

6.13 Pronouncement of Death, Autopsy and Pathology

6.13.1 Pronouncement of Death

In expected death in hospital, the decision as to who is the appropriate person to pronounce death is made collaboratively by the healthcare team.

6.13.2 Medical Certificate of Death

The MRP or delegate shall complete the medical certificate of death and stillbirth as soon as possible and not more than 2 (two) working days after death or stillbirth.

6.13.3 Report to the Coroner

As stated by the *Coroner's Act*, anyone who believes the circumstances of death meet the criteria for reporting outlined in the Coroner's Act can notify the Coroner or a peace officer.

6.13.4 Autopsy

No autopsy shall be performed without order of the Coroner or written consent of the appropriate relative or legally authorized agent of the patient.

6.13.5 Permission for Autopsy

In appropriate cases, the MRP or delegate shall make all reasonable efforts to obtain permission for the performance of an autopsy.

6.13.6 Diagnostic Material

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

6.13.7 Pathology Specimens

Pathology specimens including body tissues, organs, materials, and foreign bodies shall not be released without due authorization of the Department Head of Pathology and Laboratory Medicine or delegate.

6.14 Medical Care in Long-Term Care Facilities Operating under the Hospital Act

The IHA operates a number of long-term care facilities under Part 2 of the *Hospital Act*. The IHA Medical Staff Rules apply to Practitioners providing care in IHA-operated care facilities.

This section highlights unique rules that guide the medical care of residents in long-term care facilities.

6.14.1 Most Responsible Practitioner (MRP)

6.14.1.1 The medical care of every resident shall be directed and authorized by an appropriately-privileged Medical Staff member who shall have primary responsibility for the care of the resident. This Practitioner shall be identified as the MRP.

6.14.1.2 MRP's are those Practitioners who agree to accept residents within a long-term-care Facility under their medical direction. The MRP shall be determined either prior to, or at the time of admission.

6.14.1.3 In urgent situations where the MRP is not available, other duly-qualified practitioners may provide immediate care. The MRP shall be informed subsequently that such care was provided.

6.14.2 Admission to a Long-Term Care Facility

6.14.2.1 Every resident shall be admitted and attended by a member of the Medical Staff who has appropriate privileges and has agreed to take primary responsibility for the care of the resident and who has primary responsibility for the care of the resident.

6.14.2.2 When a resident is admitted to a long-term care facility, the MRP or delegate shall submit a complete and updated medical record as outlined in Article 6.10.1.2.

6.14.3 Care and Treatment

6.14.3.1 The MRP or delegate shall note special precautions regarding the care of the resident on the order sheet in the resident's record at the time of admission (e.g. infectious disease, emotional disturbance, etc.).

6.14.3.2 Directives for care (MOST) shall be completed in a timely manner, preferably before admission, and updated as clinically indicated and at least annually.

6.14.3.3 The MRP or delegate shall visit the newly admitted resident within seven (7) days and thereafter at least every ninety (90) days, or more frequently if clinically indicated.

6.14.3.4 All orders for medical treatment shall be legibly written, faxed, or entered electronically in Facilities where CPOE is deployed, and signed by the MRP or designate. An order for medical care or treatment may be dictated over the telephone to a registered nurse or licensed practical nurse. Telephone orders at CPOE sites, upon order entry, orders shall be notated as "telephone orders" on behalf of the ordering Medical Staff member, and shall be assigned to that member for electronic co-signature. Such orders shall be countersigned by the ordering practitioner as soon as possible, but no longer than seven (7) days following dictation.

6.14.3.5 Orders pertaining to other professional disciplines, (e.g. occupational therapist, physical therapist, dietitian, pharmacist) may be dictated by the medical practitioner to a member of that discipline who will read the order back to the practitioner for confirmation prior to its being carried out.

6.14.3.6 Dentists treating residents shall enter in the resident's health record a description of every dental treatment or procedure performed immediately following the provision of care.

6.14.3.7 Only members of the Medical Staff holding appropriate privileges at IHA may provide on call coverage for IHA Medical Staff in IHA facilities.

6.14.3.8 The MRP or delegate shall carry out a Medication Review every ninety (90) days or more frequently in collaboration with the Medical Director or Medical Leader, pharmacist or nurse, as appropriate. Medications shall be re-authorized every ninety (90) days by updating and signing the drug profile or rewriting drug orders on the order sheet.

6.14.3.9 All orders for controlled drugs and antibiotics shall have a stated limit as to the number of doses, or the hours or days of administration. The ordering practitioner shall countersign telephone orders for controlled drugs within seven (7) days. For drug orders given without such dosage or time limit, an automatic stop order shall be in effect.

6.14.3.10 If, in the opinion of the nurse in charge, the condition of the resident changes significantly, the MRP or delegate shall be informed and shall act promptly according to the urgency of the situation.

6.14.3.11 The MRP or delegate shall obtain a consultation when appropriate.

6.14.3.12 Practitioners requested to see a resident in consultation shall be members of IHA's Medical Staff and shall provide a written report for the resident's chart.

6.14.3.13 The MRP or delegate shall be asked to attend interdisciplinary conferences to discuss and plan resident care. In the absence of the MRP or delegate, the Medical Director or Medical Leader shall make recommendations regarding care to the multidisciplinary team and the MRP or delegate.

6.14.3.14 If, in the opinion of the Medical Director or Medical Leader, the condition of a resident is such that it poses a risk to other residents or to staff, and appropriate consultation, referral or transfer has not been arranged by the MRP or delegate, such consultation, referral or transfer may be arranged by the Medical Director or Medical Leader.

6.14.3.15 The MRP or delegate shall visit the resident within a week of the resident returning from acute care and provide an update in the resident's chart.

6.14.3.16 The MRP or delegate shall visit to pronounce death within a reasonable time after notification. In the event of an expected death, the MRP or delegate may transfer the responsibility for "pronouncement of death" to a registered nurse in charge of the resident's care, provided the MRP or delegate has visited the resident within the previous thirty (30) days and documented on the resident's chart that death may be expected shortly. In the event of an unexpected death, death due to unnatural cause, or death with unusual circumstances, the MRP or delegate is required to attend for the purpose of "pronouncement of death" and to review the circumstances surrounding the death. Completion of a "Certificate of Death" remains the responsibility of the MRP or delegate in all circumstances. Members of the Medical Staff pronouncing death shall record the time, date and cause of death (if known) on progress notes.

6.14.3.17 The MRP or delegate shall notify the Coroner of deaths that require notification under the *Coroner's Act.*

6.14.4 Long-term Care Medical Director

In any IHA Facility with a contracted site medical director, the medical director may provide direct care to residents without prior consultation with the MRP. When care has been provided based on any provisions in this article, the MRP shall be informed as soon as possible. Such direct care is limited to:

6.14.4.1 Treatment changes, following a multidisciplinary care-conference review, where the MRP has been invited and has not attended, or where there is a team consensus that the change is in the best interest of the resident. In such cases the resident or their substitute decision maker must have been included in reaching consensus;

6.14.4.2 Referral for a psychiatric consultation where nursing staff and the medical director deem it necessary for the ongoing care of the resident or the safety and protection of other residents or staff;

6.14.4.3 Medical orders to comply with infection prevention and control requirements or recommendations of the Medical Health Officer;

6.14.4.4 Routine medical orders where the MRP has failed to respond to requests for care in a timely manner;

6.14.4.5 Urgent medical care where the MRP is not available or has failed to respond to requests for care.

6.14.5 Health Records

6.14.5.1 Admission Record

When a resident is admitted, a record of a complete medical history and physical examination will be provided by the MRP or delegate as soon as possible within 7 (seven) days.

6.14.5.2 Progress Notes

Progress notes shall be documented at each visit and at least every ninety (90) days thereafter. Progress notes shall be sufficient to describe changes in the resident's condition, reasons for change of treatment and outcome of treatment.

6.14.5.3 Discharge Record

Within seven (7) days following the death or discharge of a resident, the MRP or delegate shall complete (dictated or electronically-entered) the resident's discharge summary using a HAMAC-approved discharge template. The discharge summary shall conform to the IHA EHR documentation policy. It shall be completed electronically in Facilities where the EHR has been deployed.

6.15 **Delegation of a Medical Act**

The process of delegation of a medical act to another healthcare professional must comply with the provisions of the *Health Professions Act* of BC. The Medical Staff may delegate certain acts in accordance with the following principles:

6.15.1 Delegation is required for acts reserved for physicians under the Bylaws of the College of Physicians and Surgeons of BC. These acts fall outside the normal scope of practice of the healthcare professional to whom the act is delegated.

6.15.2 The delegation of a medical act requires formal agreement and joint recommendation by the HAMAC and the IHA Professional Practice Office (PPO), or appropriate committee of the PPO.

6.15.3 The Board of Directors, on receiving a recommendation from the HAMAC and the PPO, must approve a delegated medical act before it can be performed by a delegate within the Facilities and Programs of the IHA.

6.15.4 Where the delegated medical act is delegated to a Regulated Professional (e.g. nursing), the request for delegation of the reserved act must then be forwarded to the Board of the College of Physicians and Surgeons of BC and the Board of the provincial Regulatory Body of the healthcare provider to whom the act is to be delegated. Approval of both these Boards is required before the delegation can be enacted in the Facilities and Programs of the IHA.

6.15.5 Each IHA Department / Division / Program will have an identified Delegating Medical Staff individual. The Department / Division / Program Head will act in this function, unless otherwise specified.

6.15.6 Regardless of the decision in 6.15.2, above, the decision to delegate remains that of the Delegating Medical Staff, and the decision to accept the delegation remains that of the individual healthcare provider approved as a delegate.

6.15.7 The Delegating Medical Staff, in partnership with the PPO, must ensure that the required knowledge and skills are appropriately taught, and confirm that the receiving healthcare provider has the competence to perform the reserved act.

6.15.8 Documented instructions must be provided for the delegated act.

6.15.9 The PPO is responsible for ensuring that ongoing competence is maintained through continuing education, experience, re-evaluation and retraining.

6.15.10 The PPO must ensure that a record is maintained naming those healthcare providers who are qualified and approved to perform delegated medical acts.

Article 7 – Quality and Safety of Care

As stated in the Bylaws, a purpose of the Medical Staff is to be accountable for the quality of medical care provided in the Programs and Facilities of the IHA. To achieve this purpose, Medical Staff are critical as leaders, active contributors, or participants.

This purpose is supported through activities outlined in the IH Quality and Patient Safety Focus areas. Specifically:

Culture and People: Ensuring dignity and respect for all individuals, with open communication and information sharing, collaboration, psychological safety, a respectful workplace free of discrimination and racism and interdisciplinary teamwork. Fostering trust.

Quality Learning Systems: Continuous improvement in care design and delivery and improvement capacity.

Quality and Patient Safety Management: Prioritization of improvements and response to harms based on review of performance / population needs and response to adverse events and care concerns.

Patient, Family and Community Engagement: Foster involvement and inclusivity of patients, family members, and communities in health service design and delivery. The IHA Framework for Person- and Family-Centred Care provides guidance for this Focus area.

All members of the Medical Staff will participate as required and requested by their Department or Division Head, or other designated Medical Leader, in Quality and Safety activities. Medical Staff are expected to contribute to the following specific activities:

7.1 Quality Reviews

Quality Review activities are an integral component of the medical staff function and responsibility, focused on continual improvement.

7.1.1 These include, but not limited to:

- 7.1.1.1 Facility, Program, Network, Department or Division Quality Committees
- 7.1.1.2 Facility, Program, Network, Department or Division Clinical Audits
- 7.1.1.3 Facility, Program, Network, Department or Division Patient Safety and Quality Rounds

7.2 Responding to Adverse Events

Medical staff have a critical role in recognizing and responding to hazards, near misses, and adverse events. This is guided by IH Policy AK0400. Specifically, Medical Staff have responsibility to:

7.2.1 Report and notify others of hazards, near misses, and adverse events

7.2.2 Respond to adverse events, which includes:

- 7.2.2.1 Providing physical / psychological support for the patient and family, employees and Medical Staff
- 7.2.2.2 Participating in adverse event reviews

7.2.2.3 Leading or participating in disclosure, including Restorative Approaches

7.2.2.4 Leading or participating in Accountability reviews (Medical Staff quality reviews), as it pertains to adverse events

7.2.2.5 Documentation in the health record

7.2.2.6 Sharing learning, and appropriate, and leading changes to improve safety

7.3 Accreditation

Accreditation is an ongoing process of evaluation with a focus on quality and safety. This process can be supported from Accreditation Canada or through the Diagnostic and Accreditation Program, of the College of Physicians and Surgeons of B.C.

7.3.1 Medical Staff will actively participate in Accreditation processes

7.4 Responding to Care Concerns

Patients and families may raise concerns about the care they receive. This may be through the Patient Care Quality Office (PCQO), or through other channels.

7.4.1 Medical Staff will actively participate in a response to any care concerns. This will include interactions with patients and families, responding to PCQO requests, assisting in investigations, communicating a response, and providing an apology, where applicable.

7.5 Compliance with Quality and Safety Activities

7.5.1 All members of the Medical Staff are required to comply with IHA's Quality Improvement and Safety Policies, and activities in 7.1, 7.2, 7.3, and 7.4, above, where requested by their Department / Division Head, or Facility Medical Director.

7.5.2 Failure to comply with 7.5.1 will initiate a letter to the member of the Medical Staff detailing the specific non-compliance. A copy of this letter will be forwarded to the appropriate Department / Division Head.

7.5.3 Medical Staff receiving a second letter for the same act of non-compliance for failure to comply with 7.1.1 will meet with the Department Head and the Facility Medical Director, or designate, within seven (7) working days. The meeting will be documented and a summary will be added to his/her personnel file.

7.5.4 Medical Staff receiving a third letter for the same act of non-compliance will be automatically suspended from the Medical Staff for a period not less than seven (7) days. An automatic letter of conduct will be added to his/her personnel file and a copy forwarded to the Chair of the HAMAC. This notice will be forwarded to the College of Physicians and Surgeons of B.C. as required by the Health Professions Act.

7.5.5 Medical Staff receiving a fourth letter for the same act of non-compliance will be referred to HAMAC and the Board for revocation of privileges and then must reapply.

7.6 **Assurances**

7.6.1 Medical Staff quality and safety activities are protected under Section 51 of the Evidence Act and, in accordance with IHA policy regarding Freedom of Information and Protection of Privacy Act (FOIPPA). It should be noted that Section 51 of the Evidence Act overrides FOIPPA.

7.6.2 Medical Staff will not be held accountable for system and / or organizational factors that impact quality and safety over which they have no control.

7.6.3 Medical Staff will be treated with care, compassion, support, respect and dignity in IHA's response to adverse events and care concerns.

7.6.3 Medical Staff involved in adverse events may experience psychological harm; appropriate supports and referrals will be provided.

7.6.4 Medical Staff have the option for consultation and advice from independent legal counsel, including from their respective Protective Associations.

Article 8 - Organization of the Medical Staff

8.1 General Organization

8.1.1 Departments and Divisions

Departments and Divisions may be organized at the level of the Health Authority or at the level of individual sites as deemed appropriate by the Board.

After considering the recommendations of the HAMAC, the CEO and the Board, shall from time to time:

8.1.1.1 organize the Medical Staff or any part thereof into such Departments and Divisions as it may see fit and shall as provided herein

8.1.1.2 appoint the Heads thereof

8.1.1.3 assign all members of the Medical Staff to a Department or Division, according to the qualifications of each member.

8.2 Medical Staff Departments

8.2.1 Article 7 of the Medical Staff Bylaws describes, in general terms, the organization of the Medical Staff, Medical Staff Departments, and the responsibilities of the Department Head.

8.2.2 The IHA maintains a medical leadership structure in support of the governance and clinical operations of the Health Authority. In accordance with Article 7 of the Bylaws, the Board, upon the advice of the HAMAC, shall organize the Medical Staff into Departments, Divisions and Sections.

8.2.3 Departments are ideally IHA-wide structures but may be Facility-based during a time of transition to IHA-wide Departments. The scope of academic and clinical activity is specific to each Facility. Departments shall not necessarily have members or Divisions at every Facility, depending on local need, practice sustainability and health-care-resource availability.

8.2.4 Departments shall be comprised of Medical Staff members who belong to the same medical or clinical discipline.

8.2.5 Department members shall assist the Department Head in monitoring the quality of patient care and the services provided by their members. All Department members shall participate in Quality Review activities, as outlined in Article 7 – Quality Reviews.

8.2.6 All members of the Medical Staff shall belong to at least one Department and maintain Privileges in at least one site within the IHA.

8.2.7 The IHA Medical Staff Departments are:

Anaesthesia
Dentistry
Diagnostic Imaging
Emergency Medicine
Family Practice
Hospitalist Medicine
Laboratory Medicine
Medicine
Midwifery
Nurse Practitioners
Obstetrics and Gynecology
Pediatrics
Psychiatry
Public Health
Surgery

8.3 **Medical Staff Divisions**

Individual Departments and Programs may be further organized into Divisions of Medical Staff members with clearly defined sub-specialty interests.

8.4 **Department / Division Meetings**

8.4.1 Departments and Divisions shall meet regularly to conduct administrative affairs, clinical appraisals, teaching, research and service commitments. Each is responsible for studying, investigating and evaluating the care provided by its members for the purpose of improving care, and Department Heads shall report regularly on these activities to the appropriate LMAC, RMAC or the HAMAC.

8.4.2 Each Department shall meet at least five (5) times per annum and at the call of the Department Head to discuss matters or importance to the IHA and to the Department.

8.4.3 Department Heads shall meet with their Division Heads at least five (5) times per year, or more often as circumstances dictate.

8.4.4 Each Division shall meet at least four (4) times per annum and at the call of the Division Head to discuss matters or importance to the IHA and to the Division.

8.4.5 Records of all duly-called meetings shall be kept and attendance shall be recorded.

8.4.6 Provisional and Active Medical Staff members are required to attend 70% of their primary Departmental and Divisional meetings unless excused in advance by the Department or Division Head.

8.4.7 Quality Review activities during Department meetings shall be privileged pursuant to Section 51 of the *Evidence Act*, shall be separated from other records and shall be compiled under the heading: "THIS REVIEW IS PROTECTED UNDER SECTION 51 OF THE BRITISH COLUMBIA EVIDENCE ACT."

8.4.8 A quorum shall consist of 50% of the voting members of each of the Department or Division.

8.4.9 Voting on all motions shall be by a show of hands, or by secret ballot as directed by the Department Head or by a majority of those present. In cases of a split vote, the Department Head shall cast the deciding vote.

8.5 Medical Staff Wellness

Medical Staff Departments shall support the health and well-being of its members. Department Heads, in collaboration with Senior Facility Medical Administrators and Executive Medical Directors, shall work with the Senior Executive Medical Administrator and the IHA to:

8.5.1 promote health and wellness amongst Medical Staff;

8.5.2 encourage a healthy and respectful workplace;

8.5.3 establish mechanisms to identify Medical Staff at risk or who need assistance;

8.5.4 develop strategies and supports for timely, respectful intervention for Medical Staff;

8.5.5 establish mechanisms to withdraw from practice impaired Medical Staff, report impaired Medical Staff, support recovery and transitions to resuming practice;

8.5.6 assist in the development and implementation of Medical Staff Wellness programs.

8.6 Appointment of Department and Division Heads

8.6.1 Department Heads shall be appointed by the Board of Directors on the recommendation of the Senior Executive Medical Administrator, whose recommendation shall be given after receiving advice from the HAMAC.

8.6.2 All active Medical Staff members within a Department may be eligible to hold the position of Department Head.

8.6.3 The term of appointment for each Department Head shall not exceed three (3) years. The Board of Directors may reappoint a Department Head for a second three (3) year term after receiving advice from the Senior Executive Medical Administrator, based on the progress of the Department under the Department Head's leadership, and a review of the Department Head's performance during the appointment term.

8.6.4 The Department Head shall be selected on the basis of qualifications, training, leadership experience and satisfactory references; as well as demonstrated clinical, academic and administrative ability.

8.6.5 The appointment and remuneration for the Department Head shall be detailed in a contract outlining the purpose, responsibilities, accountabilities and objectives of the role.

8.6.6 A Facility-based Department Head shall report through the Senior Facility Medical Administrator to the IHA Senior Executive Medical Administrator.

8.6.7 A Facility-based Department Head, or formal designate, shall attend all meetings of the LMAC as a voting member and participate on LMAC sub-committees at the request of the LMAC Chair.

8.6.8 An IHA-wide Department Head shall report directly to the Senior Executive Medical Administrator.

8.6.9 An IHA-wide Department Head, or formal designate, shall attend all meetings of the HAMAC as a voting member and participate on HAMAC sub-committees at the request of the HAMAC Chair.

8.6.10 Departments may name an Assistant Department Head, or designate, selected by the Department Head, who assumes all the responsibilities in the absence of the Department Head.

8.6.11 An Interim Department Head or Interim Division Head may be appointed by the Board on the recommendation of the CEO and HAMAC and the Department Head concerned for a period of six (6) months.

8.7 Responsibilities of Department Heads

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

The specific responsibilities of the Department Head are outlined within the Department Head contract, as provided by IHA. These shall include:

8.7.1 Organize, direct and govern the Medical Staff members within the Department;

8.7.2 Develop annual operating objectives for the Department, in partnership with operational leadership;

8.7.3 Organize, plan and chair Department meetings as required by these Rules;

8.7.4 Develop and maintain specific job descriptions for the Head of each Division;

8.7.5 Appoint Division Heads within the Department, ensuring that the HAMAC is notified of these appointments;

8.7.6 Lead and support standards and processes for the provision of high-quality, evidence-informed care to patients and their families;

8.7.7 Establish acceptable standards of behaviour for members of the Department, as prescribed by the members' provincial regulatory body, the Bylaws, these Rules and the health-human-resource policies of the IHA;

8.7.8 Advise appropriate LMACs, RMACs or HAMAC regarding the quality of medical care the Department provides, as well as Department members' compliance with professional standards;

8.7.9 Lead, participate and delegate Department members and resources for Quality Review activities;

8.7.10 Advise the Board of Directors, through the HAMAC and the Board Quality Committee, on the adequacy of resources affecting the quality of medical care and academic activities within the IHA;

8.7.11 Function as the direct communication link between the Department and the MAC structure;

8.7.12 Keep members of the Department informed and updated on the IHA's leadership strategies, objectives, policies and ongoing activities;

8.7.13 Ensure all new department members are appropriately oriented to IHA Facilities, Programs and services, including completion of IHA EHR competency training, prior to commencement of their Privileges;

8.7.14 Review and make recommendations on the operating budget for the Department, in partnership with operational leaders;

8.7.15 Monitor and evaluate the utilization of IHA resources by Department members to ensure effective and efficient use of these resources;

8.7.16 Develop and maintain a health-human-resources plan for the Department, and recruit new members in accordance with the plan, consistent with the established care Facilities, requirements and resources of the IHA;

8.7.17 Evaluate and make recommendations about persons wishing to be appointed or reappointed to the Medical Staff, including fully-completed impact-analysis reviews; and make recommendations regarding Privileges, including Procedural Privileges where appropriate, consistent with the requirements of the Department, the Facility or Program, and the IHA;

8.7.18 Review and make recommendations to the HAMAC concerning the annual review or in-depth review, and Privileges for all members of the Department; or members of other Departments, when called upon by the HAMAC to do so;

8.7.19 Identify Department members with potential or established impairment and assist with Senior Medical Directors to refer these members to programs that support practitioner health and well-being, with the aim of promoting recovery and re-entry into professional practice;

8.7.20 Where required by the Bylaws, these Rules and IHA policies, recommend to the Senior Executive Medical Administrator the restriction or suspension of Privileges of any Department member whose clinical care or behaviour could reasonably be deemed to be detrimental to the well-being of patients and staff members in particular, or the effective functioning of any IHA Facility in general; and, if necessary, appoint

another member of the Medical Staff to care for patients who have been the responsibility of that Medical Staff member until such time as a formal review can occur;

8.7.21 Consider and make recommendations regarding all applications for Department member leaves of absence;

8.7.22 Ensure that Department members are assigned to provide continuous on-call coverage to Facilities and unattached patients;

8.7.23 Foster and mentor the continuing professional development of Department members, including clinical, teaching and research objectives of the Department and the IHA;

8.7.24 Equitably allocate any available compensated academic resources to facilitate Department education and research priorities;

8.7.25 Work with the UBC to ensure education and research objectives are being adequately promoted and supported.

8.8 Responsibilities of Division Heads

8.8.1 Department Heads shall appoint Division Heads for a term not to exceed three (3) years, renewable once upon successful review.

8.8.2 Division Heads shall be, or be eligible to immediately become, members of the Active Medical Staff, selected on the basis of qualifications, training, experience and demonstrated leadership ability in clinical, teaching and administrative activities.

8.8.3 The responsibilities of the Division Head shall be similar, but subordinate, to those of the Department Head and shall be focused on the specific activities of the Division.

8.8.4 The Division Head shall report to the Department Head on all clinical, educational, research and administrative matters within the Division.

8.9 Selection Process

8.9.1 Selection process for Department Head

Where a vacancy exists for the position of Department Head and the IHA Senior Executive Leadership Team (SET) has expressed a desire that the vacant position be filled, the Senior Executive Medical Administrator, Executive Medical Director, or Senior Facility Medical Director shall strike a selection committee, advisory to the Senior Executive Medical Administrator, to recommend a candidate to fill the vacancy.

8.9.2 Selection process for Division Head

When a vacancy exists for the position of Division Head and the Department Head has expressed a desire that the vacant position be filled, the Department Head shall strike a selection committee**,** advisory to the Head**,** to recommend a candidate to fill the vacancy.

8.9.3 Decision for Department / Division Head

The HAMAC shall consider the selection committee recommendation and make its recommendation to the IHA Senior Executive Medical Administrator, who shall consider the HAMAC's recommendation in making the final candidate selection.

8.10 Review / Reappointment of Department / Division Head

8.10.1 The Senior Executive Medical Administrator, or designate, shall conduct an annual performance review of each Department Head.

8.10.2 Within the final year of the three (3) year term, the review should include recommendations regarding reappointment or non-reappointment of the Department Head for another term.

8.10.3 Department Heads are responsible to perform similar annual and end-of-term performance reviews for their Division Heads.

8.10.4 The Senior Executive Medical Administrator shall make the final decision on reappointment after receiving advice from the HAMAC.

8.11 Program / Network Medical Directors

8.11.1 Program / Network Medical Directors, together with their respective Administrative Program / Network Directors, lead and facilitate a collaborative inter-professional structure to enhance patient-and-client-focused care delivery.

8.11.2 The Program / Network Medical Director reports to the appropriate Vice President of Clinical Services, or designate, for operational aspects of the program; and to the Senior Executive Medical Administrator or designate for medical quality-of-care and professional-standards matters.

8.11.3 As part of their overall duties, Program / Network Medical Directors shall:

8.11.3.1 work in collaboration with other Medical Directors, Operational Directors and Department Heads to ensure that all programs support the IHA strategic plan;

8.11.3.2 support the development of management strategies that focus on interdisciplinary collaboration and decision-making;

8.11.3.3 ensure that policies and procedures are established for the delivery and evaluation of services offered within the program's core services;

8.11.3.4 work in collaboration with Department Heads on the development and promotion of clinical standards, education and research;

8.11.3.5 provide leadership and direction for quality improvement, utilization management and risk management within the program;

8.11.3.6 conjointly plan Medical Staff recruitment, appointments and availability with Medical Staff Department Heads;

8.11.3.7 perform other related duties as may be required from time to time.

8.12 **Direction of Board**

8.12.1 Nothing set forth in this Article 8 shall be construed to limit the Board's right and authority to change, modify, delete and add to each or any of the foregoing duties and obligations in such a manner and to such extent as the Board may deem necessary or appropriate.

At any time the Board of Directors, after receiving the recommendation of the HAMAC and the Department Head, may:

8.12.1.1 Withdraw such an appointment

8.12.1.2 Appoint an interim Department Head

8.12.1.3 Appoint the Department Head as Division Head of one (1) or more Divisions of the Department

8.13 **Suspension or Termination of Department or Division Head**

Notwithstanding anything to the contrary in this Article 8, the Board may, either on the recommendation of the Senior Executive Medical Administrator or, in its sole discretion, at any time, suspend or terminate the appointment of any Department Head or Division Head. In the event the Board intends to consider the suspension or termination of a Department Head or Division Head, the person involved shall be given reasonable notice of such intended consideration and shall have the right to appear before the Board and make representation.

Article 9 – Discipline and Appeal

Discipline and appeal are enabled by Article 11 of the Bylaws. The Rules outline the disciplinary and appeal processes and procedures for Medical Staff practicing within the Facilities and Programs operated by the IHA.

The IH Policy 3.15: *Safe Reporting* provides that a review of the conduct of any person associated with the IH, including a member of the Medical Staff, may be initiated through the Director, Internal Audit. The policy is intended to supplement and does not replace the established processes for the reporting, investigation, and resolution of complaints against a member of the Medical Staff as described in Article 9.

9.1 Procedural Fairness

A Concern raised with respect to a member of the IH Medical Staff [the "Subject Member"], including allegations of a breach of IHA Bylaws, Rules and Policies may result in a disciplinary process and, if deemed founded, in disciplinary action. The following terms of procedural fairness shall apply:

9.1.1 The Subject Member has the right to a copy of the Concern and a right to respond to the Concern;

9.1.2 Prior to a hearing, the parties shall disclose the evidence that shall be presented to support or refute the Concern;

9.1.3 The parties have the right to legal counsel or an advisor, the right to be heard at all hearings, and the right to present evidence and cross examine witnesses;

9.1.4 The Subject Member shall be provided with a copy of any documentation sent to the relevant College, to the extent permitted by law;

9.1.5 The Subject Member has the right to review all documentation maintained on their personnel file;

9.1.6 The parties shall maintain confidentiality consistent with the nature of the proceeding, and to the extent permitted by law, provided that the Subject Member does not present a risk to patients or the public; and

9.1.7 Hearings shall be free of bias and the Subject Member has the right to object to the composition of any hearing committee.

The following general principles of procedural fairness shall also apply:

Efficiency - A disciplinary process should facilitate the resolution of the matter under investigation as expeditiously as possible.

Clarity - A disciplinary process shall be reviewed by Medical Staff at the time of their initial appointment IH. The requirement for Medical Staff to confirm in writing they have read and agree to abide by the IHA Bylaws and Rules at the time of appointment and re-appointment shall be deemed sufficient for this purpose.

Timeliness - A disciplinary process shall be conducted in a timely fashion to ensure patient and staff safety, and to ensure the Medical Staff member is not unfairly disadvantaged. Expediency in resolving Concerns shall be balanced with ensuring appropriate time for thorough investigation, a fair process, and best decisions.

Conformity with Standards of Practice - A fair and reasonable evaluation of Medical Staff shall rely on standards of practice and professional behaviour established by the provincial regulatory body, relevant IH clinical policies and/or through expert evidence.

9.2 **A Concern**

9.2.1 A Concern with respect to a Subject Member shall be:

9.2.1.1 in writing;

9.2.1.2 Signed by either the Complainant or by the individual conveying the Concern involving the Subject Member; and

9.2.1.3 Supported by a reasonable degree of relevant detail forming the basis of the Concern.

9.2.2 A Concern may be received from a Complainant or, if deemed warranted, may be initiated by IH or brought by IH on behalf of a Complainant.

9.2.3 The basis of a Concern may include, but are not limited to:

9.2.3.1 quality and safety of patient care;

9.2.3.2 clinical performance;

9.2.3.3 participation in continuing professional development and maintenance of competence activities relevant to the Medical Staff;

9.2.3.4 ethical conduct;

9.2.3.5 professional behaviour and conduct including interactions with patients, families, visitors, professional colleagues, and IH clinical and non-clinical staff;

9.2.3.6 breach of the responsibilities and expectations pursuant to the Bylaws, the Rules, IH policies, the Professional Code of Conduct of the relevant College and/or the respective code of ethics of the relevant profession;

9.2.3.7 breach of any formal agreement with IH;

9.2.3.8 Any health problem that significantly affects the ability of the Medical Staff to carry out their IH professional responsibilities; and,

9.2.3.9 Any retaliatory actions against a Complainant.

9.2.4 The Complainant shall be notified that the Concern has been received and has been forwarded to an appointed IH medical leader for consideration and, if appropriate, for an investigation.

9.3 Procedures for Investigation and Management of a Concern

9.3.1 The IH medical leader that is appointed to manage the Concern [the "Appointed Medical Leader"] shall initially assess the Concern to determine its seriousness, including whether further action under the Rules is warranted. If further action is deemed warranted, the Appointed Medical Leader shall consider the appropriate stage of intervention, as provided in 9.3.4.

9.3.2 At any time during the process under 9.3 the Appointed Medical Leader can recommend, or the Subject Member can request, that the process be addressed through consensual resolution. Consensual resolution discussions shall be confidential and without prejudice to the parties and the process under 9.3. If there in an opportunity to resolve the Concern by consensual resolution, the Appointed Medical Leader shall prepare a report to the Senior Facility Medical Administrator and the Senior Executive Medical Administrator, or designate, who shall decide, within fourteen (14) days, whether consensual resolution of the Concern is appropriate.

9.3.3 The Appointed Medical Leader shall consult with the Senior Facility Medical Administrator and the Senior Executive Medical Administrator prior to initiating a Stage 1, Stage 2, or Stage 3 intervention, unless Crisis Intervention is deemed warranted by the Appointed Medical Leader.

9.3.4 Interventions by IH shall follow a staged approach, as described below:

9.3.4.1 **Stage 1**: is warranted for behaviour that meets criteria for unprofessional conduct that cannot be resolved informally, or where unprofessional behaviour appears to be part of a recurring pattern.

9.3.4.2 **Stage 2**: is warranted where a Stage 1 intervention has been ineffective.

9.3.4.3 **Stage 3**: is warranted for significant unprofessional behaviour or for serious clinical concerns that persist despite a Stage 2 intervention.

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

9.4 Staged Intervention Process

9.4.1 Stage 1 Intervention

The Appointed Medical Leader, in consultation with Senior Facility Medical Administrator, shall:

i. Meet with the Subject Member to discuss the Concern and review any relevant documents.

ii. Provide the Subject Member with an opportunity to respond to the Concern;

iii. Discuss with the Subject Member how others have interpreted or received the conduct giving rise to the Concern; and

iv. Offer advice, guidance, and information on how to access support resources, if required;

Following discussion with the Subject Member the Appointed Medical Leader shall decide the format and substance of a resolution to the Concern, including a response to the Complainant; and document the Stage 1 Intervention process to be kept on the personnel file of the Subject Member.

Stage 1 intervention should be completed within four (4) weeks of receiving the Concern.

9.4.2 **Stage 2 Intervention**

The Appointed Medical Leader, in consultation with the Senior Facility Medical Administrator, shall conduct an initial meeting, as described in the Stage 1 Intervention. The Appointed Medical Leader and Senior Facility Medical Administrator shall then work with the Subject Member to develop a remediation plan, which shall include the following:

i. A method for redress, which may include but is not limited to, education, coaching, counselling, practice supervision or supervision of practice in another program, with regular reports to be received by the Appointed Medical Leader;

ii. A requirement to participate in psychological or other medical testing; substance use therapy; leadership training; written project or tutorial sessions including referral of the Subject Member to an external resource such as a Practitioner Health Program;

iii. Quality metrics sufficient to determine whether the remediation plan was successful;

iv. A time frame within which progress must be demonstrated by the Subject Member; and

v. The failure to complete the remediation plan shall result in a new Concern.

If the Subject Member agrees with the remedial plan, the Appointed Medical Leader shall notify the Medical Staff member in writing that another substantiated incident shall result in a review by the HAMAC in accordance with the Bylaws, and that Medical Staff Privileges may be modified or terminated at that time.

If an agreement on the remediation plan is not reached within thirty (30) days from the time the Subject Member receives the proposed remediation plan the remediation plan shall be finalized by the Appointed

Medical Leader, taking into account any feedback received from the Subject Member, and:

i. If the proposed remediation plan does not impact the medical appointment of privileges of the Subject Member, it shall be forwarded to the HAMAC with a recommendation from the Appointed Medial Leader that the remediation plan be unilaterally imposed on the Subject Member; or

ii. If the proposed remediation plan impacts the medical appointment of privileges of the Subject Member, it shall be forwarded to the RMAC for the following review process:

a. The Subject Member shall have the opportunity to provide written submissions to the RMAC detailing any objections to the proposed remediation plan;

b. The RMAC may initiate an external review and incorporate any findings into the remediation plan; and,

c. If the Subject Member still does not agree with the proposed remediation plan, the RMAC shall forward it to the HAMAC recommending that it be unilaterally imposed on the Subject Member.

9.4.3 **Stage 3 Intervention**

The Appointed Medical Leader and the Senior Facility Medical Administrator shall immediately involve the Senior Executive Medical Administrator and the HAMAC Chair.

A review of the Concern by the HAMAC shall be scheduled as soon as possible. The Senior Executive Medical Administrator, or designate, is responsible to oversee and manage the Stage 3 intervention. The HAMAC shall:

i. Review the Concern, the behavioural or clinical history of the Subject Member and any relevant evidence;

ii. Hear and consider any evidence or submissions made on behalf of the Subject Member; and

iii. Make a recommendation to the IH Board of Directors with respect to disciplinary action, including, but not limited to:

1. Modification, suspension, revocation, or refusal to renew the privileges and appointment of the Subject Member; and,

2. Any other conditions the HAMAC deems appropriate.

9.4.4 **Crisis Intervention**

Where the Concern constitutes a serious problem or potential problem which adversely affects or may adversely affect the care of patients and

is not appropriate for a staged intervention, the Appointed Medical Leader and the Senior Facility Medical Administrator shall make the CEO and/or the Senior Executive Medical Administrator aware and recommend a summary suspension of privileges pursuant to Article 11.2.1 of the Bylaws.

9.5 Automatic Temporary Suspension

Further to Article 11.3.1 of the Bylaws, a member of the Medical Staff shall receive an automatic temporary suspension of privileges in circumstances including, but not limited to, where the member of the Medical Staff has:

a. Abandoned a patient admitted to an IH Facility;

b. Committed a criminal offence while exercising clinical privileges;

c. Had their license to practice revoked by the provincial regulating body;

d. Provided clinical care, the exercising of clinical privileges, or the fulfillment of contractual arrangements for the provision of patient care, while impaired by drugs or alcohol; or

e. Failed to comply with the completion of Health Records as described in Section 6.10 of these Rules.

Article 10 – Health Authority Medical Advisory Committee

10.1 **Purpose**

As listed in 8.1 of the Bylaws, the purpose of the HAMAC shall be:

10.1.1 To function as the senior medical leadership committee within the IHA.

10.1.2 To provide advice and recommendations to the IHA Board and CEO on the provision of medical care, the monitoring of the quality and effectiveness of medical care, the adequacy of medical staff resources, the continuing education of the Medical Staff and the planning goals for meeting the medical care needs of the population served by the IHA.

10.1.3 To provide advice and recommendations to the IHA Board and CEO on any matters pertaining to the appropriate organization governance, management and discipline of the IHA Medical Staff.

10.2 **Authority**

HAMAC has the authority:

10.2.1 to ensure compliance by the Medical Staff with the *Hospital Act*, the Health Authorities' Act and relevant regulations, the Bylaws, these Rules, and the policies of IHA;

10.2.2 to appoint sub-committees of the HAMAC;

10.2.3 to exercise discipline within and up to the limitations of authority delegated by the Board of Directors on any Medical Staff, including the issuing of reprimands or a request to participate in educational or remedial programs; and

10.2.4 to require any member of the Medical Staff to appear before it whenever necessary to carry out its responsibilities.

10.3 **Duties and Responsibilities of the HAMAC**

10.3.1 Medical Administration

The HAMAC has the authority to, and shall:

10.3.1.1 Appoint chairs and members of standing committees and ensure these committees function effectively, including recording minutes of the meetings;

10.3.1.2 Make recommendations to the Board of Directors on the development, maintenance, review and revision of these Rules and policies pertaining to medical care provided within the Facilities and Programs operated by the Authority;

10.3.1.3 Advise and make recommendations to the Board on matters pertaining to medical technology, the clinical organization of the Medical Staff and any other administrative matters affecting the Medical Staff;

10.3.1.4 Make recommendations to the Board regarding general disciplinary measures for violation of the Bylaws, Rules or policies governing the conduct of the Medical Staff;

10.3.1.5 Review and report any concerns related to the professional and ethical conduct of members of the Medical Staff to the Board and, where required by provincial legislation, report those concerns to the appropriate provincial regulatory body;

10.3.1.6 After reviewing reports from the Credentialing and Privileging Committee, make recommendations to the Board on the appointment, reappointment, privileging and review of Medical Staff members;

10.3.1.7 Establish professional standards of practice and conduct for Medical Staff members in Facilities and Programs operated by the IHA, in compliance with all relevant provincial legislation and the IHA Bylaws, Rules and policies;

10.3.1.8 Make recommendations for the continuing professional development of members of the Medical Staff;

10.3.1.9 Make recommendations to the Board for the renewal, restriction, suspension, cancellation or non-renewal of Medical Staff appointments and privileges;

10.3.1.10 Report to the Board on the Medical Staff resources required to meet the healthcare needs of the population served by the IHA, including the availability and adequacy of existing resources to provide appropriate patient care.

10.3.2 Quality of Care

The HAMAC has the authority to, and shall:

10.3.2.1 Review and make recommendations on matters related to the quality and safety of the medical care provided within the Facilities and Programs operated by the IHA;

10.3.2.2 Receive, review and make recommendations on reports from Quality Review activities concerning evaluation of the clinical practice of members of the Medical Staff;

10.3.2.3 Ensure Medical Staff members comply with the *Hospital Act* and its Regulation, and with the Bylaws, Rules and policies;

10.3.2.4 Establish ad hoc sub-committees to recommend Medical Staff disciplinary action, including reprimands, within and up to the limitations of authority delegated by the Board;

10.3.2.5 Make recommendations on the supervision of clinical practice.

10.3.3 Medical Staff Resource Planning

The HAMAC has the authority to, and shall:

10.3.3.1 Review information regarding the Medical Staff human resources required to meet the medical, dental, midwifery and nurse practitioner needs of the population served by the IHA and, following the review, provide advice to the Board and CEO;

10.3.3.2 Submit an annual Medical Staff Human Resource Plan to the Board.

10.3.4 Continuing Medical Education / Teaching and Research

The HAMAC has the authority to, and shall:

10.3.4.1 Advise on and assist with the development of formally-structured ongoing programs for Medical Staff continuing professional development;

10.3.4.2 Advise on, and assist where possible, with programs for continuing education for other healthcare providers in the facilities and programs operated by the IHA;

10.3.4.3 Advise on and make recommendations regarding teaching and research within IHA.

10.4 **Membership**

10.4.1 Voting members:

the IHA Senior Medical Health Officer (1)
the IHA Senior Executive Medical Administrator (1)
the Chairs of the Regional Medical Advisory Committees (4)
an elected Medical Staff Association member from each of the four health service delivery areas (4)
the IHA Department Head of Laboratory Medicine (1)
the IHA Cardiology Medical Program Director (1)
the IHA Renal Medical Program Director (1)
the Senior Facility Medical Administrators of the Royal Inland Hospital and the Kelowna General Hospital (2)
a Regional Senior Facility Medical Administrator (1)
a Long Term Care / Seniors' Health Physician Leader (1)
a Representative from the Interdivisional Strategic Council who is appointed to the IHA Medical Staff (1)
the IHA Department Head of Nurse Practitioners (1)

10.4.2 Non-voting members:

the IHA Board Chair
the IHA CEO
the IHA Vice Presidents accountable for Clinical Operations
the IHA Vice President Quality, Research and Academic Affairs
the IHA Chief Nursing Officer
the IHA Executive Medical Directors
the IHA Medical Director of Patient Transportation Services .

10.4.3 Ad-hoc members:

a. the remaining IHA Vice Presidents
b. Other professional, clinical or administrative members appointed from time to time to fulfill specific roles as required by the HAMAC
c. Department of Medical Affairs support staff.

10.5 **Officers and Terms**

10.5.1 There shall be a Chair and Vice-Chair of the HAMAC.

10.5.2 The Chair shall normally be selected from among the voting members of the HAMAC. Where the Chair is a Medical Staff member not selected from the HAMAC voting membership outlined in 10.4.1 above, the total committee membership shall increase by one member for the duration of that Chair's appointment.

10.5.3 The Chair shall be appointed for a term of not more than three (3) years, and may be re-appointed for one additional term for a maximum of two consecutive terms.

10.5.4 The Vice-Chair shall be selected from among the voting members of the HAMAC.

10.5.5 The Vice-Chair shall be appointed for a term of not more than three (3) years, and may be re-appointed for an additional term for a maximum of two consecutive terms.

10.5.6 The Office of the Senior Executive Medical Administrator shall provide secretariat services to the HAMAC.

10.6 **Chair**

10.6.1 Six months prior to the end of a HAMAC Chair's term of office, the HAMAC shall strike an ad hoc Nominations Sub-Committee. After a search and review process for a new Chair, the sub-committee shall recommend a nominee to be ratified by the HAMAC and referred to the Board for approval. The Chair shall be appointed by the Board after reviewing the recommendation of the HAMAC. The Board is under no obligation to appoint the individual so recommended.

10.6.2 The Chair shall have authority to invite any IHA Medical Staff member, staff member, or other party relevant to the business of the HAMAC to attend a HAMAC meeting to address specific agenda items. Invitees shall attend in a non-voting capacity and respect HAMAC confidentiality.

10.6.3 Duties:

10.6.3.1 Chair all meetings of the HAMAC or, if unavailable, delegate this role to the Vice Chair or another suitable candidate in the Vice-Chair's simultaneous absence;

10.6.3.2 Chair the HAMAC Executive Committee;

10.6.3.3 With a facilitator, chair the annual HAMAC retreat;

10.6.3.4 Oversee the preparation of written agendas for each meeting after seeking input from the Senior Executive Medical Administrator and Chief Executive Officer;

10.6.3.5 In conjunction with the Medical Affairs Department, manage the affairs of the HAMAC between meetings, and ensure committee and sub-committee responsibilities are discharged in a timely manner;

10.6.3.6 Oversee the HAMAC secretariat in coordinating and ensuring timely reporting by the HAMAC's subcommittees;

10.6.3.7 Represent the HAMAC at meetings of the Senior Executive Team and other relevant administrative meetings;

10.6.3.8 Attend meetings of the Board of Directors in accordance with Article 8.2.5 of the Bylaws**,** ensuring timely reporting of HAMAC issues and concerns and related recommendations;

10.6.3.9 Act as the principal spokesperson for HAMAC in liaising with the CEO and Board Chair;

10.6.3.10 Serve as an ex-officio member of all HAMAC subcommittees;

10.6.3.11 Oversee annual confirmation of the HAMAC membership and appointment of sub-committee Chairs;

10.6.3.12 Ensure the HAMAC secretariat communicates broadly to the Medical Staff on the committee's business, decisions, approved motions and advice provided to the Board, CEO and SET;

10.6.3.13 At the request of the Senior Executive Medical Administrator, CEO or Board, perform other duties relevant to the HAMAC's role and responsibilities.

10.7 **Vice-Chair**

10.7.1 An appropriate search committee of HAMAC shall recommend a nominee for Vice-Chair to be endorsed by HAMAC and referred to the Board for approval. The Vice-Chair shall be appointed by the Board after reviewing the recommendation of the HAMAC. The Board is under no obligation to appoint the individual so recommended.

10.7.2 The Vice-Chair shall serve as a member of the HAMAC Executive Committee.

10.7.3 The Vice-Chair shall act in the capacity of, and exercise the duties and responsibilities of the Chair in the Chair's absence.

10.8 **Procedures**

10.8.1 A simple majority of voting members present at all regular meetings and duly-called extraordinary meetings of the HAMAC shall constitute quorum for the meeting.

10.8.2 The success or failure of a motion before the HAMAC shall be decided by a simple majority vote (50% plus one) of those voting members present at all regular meetings and duly-called extraordinary meetings.

10.8.3 The HAMAC Chair shall not vote on any motion except where the vote is tied.

10.9 **Meetings**

10.9.1 The HAMAC shall schedule regular meetings and shall meet at least ten (10) times per year.

10.9.2 The HAMAC shall also meet at the call of the Chair to deal with special or urgent issues. In this case a formal agenda need not be issued in advance, but must be presented in writing or in electronic format at the meeting itself. All members shall be advised of the purpose of the meeting, and given as much notice as the urgency of the situation permits.

10.9.3 The IHA Medical Affairs Department shall maintain the agendas, meeting packages, minutes and any other documentation relevant to or required by the HAMAC.

10.9.4 Except under emergency circumstances, the agenda and all related material for a regular meeting shall be distributed to the members at least seven (7) days before the meeting.

10.9.5 Minutes shall be prepared on a timely basis after each meeting and made available to all voting and non-voting members within two (2) weeks following the meeting.

10.9.6 All members may suggest additions to the agenda. If a suggested addition is subsequently placed on the agenda, the Chair and the Senior Executive Medical Administrator shall be given at least a one-month's written notice to to ensure sufficient time for the development and provision of a briefing document to expedite discussion.

10.9.7 All members should submit brief reports to be included in the agenda

10.9.8 HAMAC members should participate in meetings in person, but may attend by telephone or virtually. A member participating in a meeting by any of these means shall be duly recorded as present at the meeting.

10.9.9 Members attending HAMAC meetings by telephone or virtually must assure the Chair at the start of the meeting there are and shall be no uninvited or unidentified individuals observing, listening to or recording the meeting from the remote site.

10.10 **Annual Review and Planning Meeting**

10.10.1 The HAMAC shall conduct an annual face-to-face meeting, open to all HAMAC members, Chairs of HAMAC sub-committees and others at the invitation of the HAMAC Chair.

10.10.2 The purpose of the meeting shall be:

a) To receive and review annual reports from the Chairs of the HAMAC sub-committees;

b) To review and confirm the membership of HAMAC and its sub-committees for the coming year;

c) To review HAMAC progress during the past year;

d) To create a HAMAC workplan for the coming year;

e) To develop new strategies or initiatives to improve the operational effectiveness of the HAMAC to deliver its mandate.

f) To conduct a formal self-evaluation to determine whether HAMAC is fulfilling its mandate.

10.11 **Executive Committee**

10.11.1 The HAMAC Executive Committee shall plan, develop, prioritize and finalize the agenda for each regular meeting, as well as address any business arising between regular meetings of the HAMAC at the request of the Chair or Senior Executive Medical Administrator.

10.11.2 The Executive Committee shall meet at least two weeks prior to each scheduled HAMAC meeting, and at the request of the Chair or Senior Executive Medical Administrator.

10.11.3 The Executive Committee shall be comprised of:

- The HAMAC Chair;
- The HAMAC Vice-Chair;
- The Senior Executive Medical Administrator;
- One Executive Medical Director, on a one-year rotational basis;
- One Chair from the four RMACs, on a one-year rotational basis;
- One Senior Facility Medical Administrator, on a one-year rotational basis;
- One LMAC Chair, on a one-year rotational basis;
- One IHA Medical Staff President, on a one-year rotational basis;
- One IH-wide Department Head or Medical Program Director;
- Department of Medical Affairs support staff.

10.11.4 In situations where a full HAMAC meeting is not feasible or quorum cannot be established, the HAMAC Executive Committee shall have the authority to undertake preliminary action on urgent issues. The HAMAC Executive shall report to the HAMAC at its next regularly-scheduled meeting on decisions made or actions undertaken. At this meeting, the HAMAC shall ratify, modify or rescind the actions taken by the Executive Committee.

10.12 **Reporting and Accountability**

10.12.1 The HAMAC shall make recommendations to the Board at each scheduled meeting regarding Medical Staff appointments and privileges. This report shall be provided in advance to the Board in written or electronic format compliant with the Board's established meeting protocols.

10.12.2 The Chair or Vice-Chair of the HAMAC will attend meetings of the Board and the appropriate committees of the Board.

10.12.3 Advice to the IHA on other matters within the scope of the HAMAC's duties and responsibilities shall be addressed to both the Chair of the Board and the CEO.

10.13 **Subcommittees**

10.13.1 Article 9.1.2 of the *Medical Staff Bylaws* provides that the Board of Directors, on the advice of the HAMAC, may establish other Standing Committees, reporting to the HAMAC, to undertake specific responsibilities that fall within the responsibility of the Medical Staff organization.

10.13.2 Detailed Terms of Reference for each of these Committees are attached as **Appendices**.

10.13.3 Committees may be added or deleted as the HAMAC considers which of its responsibilities may best be fulfilled through more detailed review by a Committee.

10.13.4 The Chair, in consultation with the Senior Medical Administrator will annually propose the leadership and membership for each of the Standing Committees for election by the HAMAC.

10.13.5 The HAMAC may also from time to time appoint ad hoc Committees and or Task Forces to address specific issues. In all cases there will be clear Terms of Reference which include the time limits or events that will bring the assigned mandate to a close.

10.13.6 Each Standing Committee, ad hoc Committee and Task Force will report in a timely manner to the HAMAC on the results of its meetings.

10.13.7 A committee member may be removed or replaced at any time by the HAMAC Chair and will cease to be a member.

10.14 **Regional Medical Advisory Committees (RMACs)**

10.14.1 RMAC Committees

The Board shall approve the establishment of four RMACs:

10.14.1.1 East Kootenay
10.14.1.2 Kootenay Boundary
10.14.1.3 Okanagan
10.14.1.4 Thompson-Cariboo-Shuswap

10.14.2 Purpose

10.14.2.1 Each RMAC shall have written Terms of Reference that reflect the Region's Medical Staff structure and needs.

10.14.2.2 Each RMAC makes recommendations through the HAMAC to the Board regarding appointments and privileges for new members of the Medical Staff; the maintenance of privileges resulting from the annual review process; and with respect to the cancellation, suspension, restriction, non-renewal or denial of privileges for all members of the Medical Staff within the Facilities and Programs operated by the IHA within that RMAC's Region. These recommendations require approval by the HAMAC before being forwarded to the Board.

10.14.2.3 Each RMAC also provides advice to the HAMAC on Medical Staff governance within the Facilities and Programs operated by the IHA within the Region, as outlined in the Bylaws 8.1.3 and within these Rules, 10.1.2.

10.14.3 Duties and Responsibilities

10.14.3.1 The RMAC shall have the same authority as the HAMAC for the governance of the Medical Staff practicing within the Region.

10.14.3.2 The RMAC shall share the same responsibilities and fulfill the same duties as the HAMAC, but limited to the Medical Staff practicing within the Region.

10.14.4 Membership

10.14.4.1 The voting members of each RMAC shall include:

IHA Medical Staff Department Heads and Medical Program Directors whose departments or Programs operate within the Region;

one elected representative from each Medical Staff Association within the Region;

the LMAC Chairs within the Region;

following approval by the HAMAC, other members of the Medical Staff, determined by the RMAC

10.14.4.2 The non-voting members of each RMAC shall include:

the SET Vice President with accountability for the Region, or designate;

at least one IHA Executive Medical Director appointed by the Senior Executive Medical Administrator;

the Regional Chief of Staff or designate;

Department of Medical Affairs support staff.

10.14.5 Officers and Terms

10.14.5.1 The Chair and Vice-Chair of the RMAC shall be appointed by the HAMAC and selected from a list of nominees submitted by the RMAC.

10.14.5.2 The Chair and Vice-Chair shall be selected from among the members of the RMAC or from the LMACs within the Region.

10.14.5.3 The Chair and Vice-Chair shall be appointed for a term of three (3) years, renewable for one additional term upon satisfactory review, for a maximum of two (2) consecutive terms.

10.14.5.4 The Office of the Senior Executive Medical Administrator shall provide secretariat services to the RMAC.

10.14.6 Chair

10.14.6.1 The RMAC Chair shall have the same responsibilities as the HAMAC Chair, but with governance limited to the Medical Staff practicing within the Region.

10.14.6.2 The RMAC Chair shall act as the principal spokesperson for the RMAC in liaising with the Senior Executive Medical Administrator and the SET through the Medical Affairs Leadership Structure.

10.14.6.3 The RMAC Chair shall be a voting member of the HAMAC.

10.14.6.4 The RMAC Chair shall ensure the timely communication of relevant information, concerns and recommendations from the RMAC to the HAMAC, and from the HAMAC to the RMAC.

10.14.7 Meetings

10.14.7.1 The RMAC shall schedule regular meetings and shall meet not less than six (6) times per year.

10.14.7.2 RMAC meetings, agendas and voting procedures shall be the same as those for the HAMAC, as outlined in these Rules, 10.9, above.

10.14.8 Reporting and Accountability

10.14.8.1 The RMAC shall report directly to the HAMAC.

10.14.8.2 Recommendations for Medical Staff appointments and privileges shall be made to the HAMAC in a written report. The RMAC Chair or designate shall present this report to the HAMAC and shall speak to the recommendations.

10.14.8.3 The Chair of the HAMAC shall respond to the RMAC reports, advising the Board Chair and CEO of any issues requiring the Board's attention.

10.14.8.4 The RMAC shall only report to the Board through the HAMAC, or at the request of the Board Chair.

10.15 **Local Medical Advisory Committees (LMACs)**

10.15.1 LMAC Committees

After considering the advice of the RMAC, the HAMAC has the authority to establish LMACs at individual Facilities within a Region covered by a RMAC.

10.15.1.1 Each LMAC shall function under the mandate of a RMAC.

10.15.1.2 Each LMAC reports directly to its RMAC.

10.15.2 Purpose

10.15.2.1 Each LMAC shall have written Terms of Reference that reflect the Facility Medical Staff structure and needs.

10.15.2.2 Each LMAC makes recommendations through its RMAC to the HAMAC to the Board regarding appointments and privileges for new members of the Medical Staff; the maintenance of privileges resulting from the annual review process; and with respect to the cancellation, suspension, restriction, non-renewal or denial of privileges for all members of the Medical Staff within the Facility. These recommendations require approval by the RMAC and HAMAC before being forwarded to the Board.

10.15.2.3 Each LMAC also provides advice through the RMAC to the HAMAC on Medical Staff governance within the Facilities and Programs operated by the IHA within the Region, as outlined in the Bylaws 8.1.3 and within these Rules, 10.1.2.

10.15.3 Duties and Responsibilities

10.15.3.1 The LMAC shall have the same authority as the HAMAC for the governance of the Medical Staff practicing within the Facility.

10.15.3.2 The LMAC shall share the same responsibilities and fulfill the same duties as the HAMAC but limited to the Medical Staff within the Facility.

10.15.4 Membership

10.15.4.1 The voting members of each LMAC shall include:

The Senior Site Medical Administrator;

All Facility Medical Staff Department Heads;

The Facility Medical Staff Association President;

following approval by the RMAC, other members of the Medical Staff, determined by the LMAC.

10.15.4.2 The non-voting members of each RMAC shall include:

the SET Vice President with accountability for the Facility, or designate;

one IHA Executive Medical Director appointed by the Senior Executive Medical Administrator;

The Senior Site Facility Administrator and other Site Administrators

Department of Medical Affairs support staff.

10.15.5 Officers and Terms

10.15.5.1 The Chair and Vice-Chair of the LMAC shall be appointed by the RMAC and selected from a list of nominees submitted by the LMAC.

10.15.5.2 The Chair and Vice-Chair shall be selected from among the members of the LMAC.

10.15.5.3 The Chair and Vice-Chair shall be appointed for a term of three (3) years, renewable for one additional term upon satisfactory review, for a maximum of two (2) consecutive terms.

10.15.5.4 The Office of the Senior Executive Medical Administrator shall provide secretariat services to the LMAC.

10.15.6 Chair

10.15.6.1 The LMAC Chair shall have the same responsibilities as the HAMAC Chair, but with governance limited to the Medical Staff practicing within a Facility.

10.15.6.2 The LMAC Chair shall act as the principal spokesperson for the LMAC in liaising with the Senior Executive Medical Administrator and the SET through the Medical Affairs Leadership Structure.

10.15.6.3 The LMAC Chair shall be a voting member of the RMAC.

10.15.6.4 The LMAC Chair shall ensure the timely communication of relevant information, concerns and recommendations from the LMAC to the RMAC, and from the RMAC to the LMAC.

10.15.7 Meetings

10.15.7.1 The LMAC shall schedule regular meetings and shall meet not less than ten (10) times per year.

10.15.7.2 LMAC meetings, agendas and voting procedures shall be the same as those for the HAMAC, as outlined in these Rules, 10.9, above.

10.15.8 Reporting and Accountability

10.15.8.1 The LMAC shall report directly to the RMAC.

10.15.8.2 Recommendations for Medical Staff appointments and privileges shall be made to the RMAC in a written report. The LMAC Chair or designate shall present this report to the RMAC and shall speak to the recommendations.

10.15.8.3 The Chair of the RMAC shall respond to the LMAC reports, advising the HAMAC of any issues requiring the attention of the HAMAC or the Board Chair and CEO.

10.15.8.4 The LMAC shall only report to the Board through the RMAC and HAMAC, or at the request of the Board Chair.

Article 11 – Medical Staff Association

11.1 **Role and Structure**

11.1.1 The objectives of the Medical Staff Associations (MSA's) include promoting and engaging Medical Staff involvement in the provision of the IHA's medical and clinical services, as well as representing and advocating for the interests of the IHA Medical Staff.

11.1.2 Medical Staff Associations are currently Facility specific, but the IHA MSAs may elect to establish a Regional MSA.

11.1.3 The structure and operation of the MSAs shall comply with these Rules.

11.2 **Elected Officers of the Medical Staff Assocation**

11.2.1 The elected officers of the Medical Staff Association shall be:

11.2.1.1 President of the Medical Staff Association

11.2.1.2 Other officers deemed necessary by the respective Medical Staff Association

11.2.2 Duties

The elected officers of the Medical Staff Association shall be responsible for:

11.2.2.1 Meetings – Regular, Annual and Special;

11.2.2.2 Appointing special subcommittees as needed.

11.3 **Election Procedure**

11.3.1 A slate of nominated officer(s) will be proposed by a committee constituted for this purpose; consisting of the a Past President of the Medical Staff (Chair) and two (2) other members to be appointed by the elected officers of the Medical Staff.

11.3.2 The nominated officers of the Medical Staff shall be elected at an annual general meeting of the Medical Staff and shall hold office for a period of not more than three (3) years, assuming continuous membership to the active staff.

11.3.3 All members of the Active staff are eligible to vote, stand for election, and hold office. Elections will be by acclamation or by a simple majority vote by all active members present and eligible to vote.

11.4 **President of the Medical Staff Assocation**

The President of the Medical Staff shall:

11.4.1 Convene and chair all meetings of the Medical Staff;

11.4.2 Be a member ex-officio, of all Medical Staff committees;

11.4.3 Be a voting member of the LMAC;

11.4.4 Receive information and directives from the LMAC and disseminate this information to the Medical Staff as appropriate;

11.4.5 Communicate matters of concern from the Medical Staff to the Senior Facility Medical Administrator;

11.4.6 Represent the collective interests of the Medical Staff.

11.5 **Past President of the Medical Staff Association**

The Past President of the Medical Staff shall serve in an advisory capacity, along with the President of the Medical Staff and its elected officers.

11.6 **Meetings**

11.6.1 Annual Meeting

11.6.1.1 The annual meeting shall be the last meeting of each year at which time officers shall be elected for the ensuring year.

11.6.1.2 The President of the Medical Staff shall post a notice for members of the Medical Staff at least ten (10) days prior to the annual meeting announcing the time and place of the meeting.

11.6.1.3 An annual report from the officers and committees shall be presented in writing.

11.6.1.4 An annual report on the financial affairs of the Medical Staff in the past year and a proposed budget in writing for the ensuing year presented.

11.6.1.5 Representatives of the Board of Directors shall be invited to attend.

11.6.1.6 Records of the meeting shall be kept.

11.6.2 Regular Meetings

11.6.2.1 Regular meetings of the Medical Staff shall be held at least four (4) times per year, or as deemed appropriate by the President of the Medical Staff or officers of the Medical Staff.

11.6.2.2 The President of the Medical Staff shall post a notice for members of the Medical Staff at least ten (10) days prior to a regular meeting announcing the time and place of the meeting.

11.6.2.3 The Chief Executive Officer shall be given notice of, and may attend appropriate portions of all meetings of the Medical Staff.

11.6.2.4 President(s) shall be given notice of, and may attend appropriate portions of all department meetings of the Medical Staff.

11.6.2.5 The Senior Facility Medical Administrator may attend appropriate portions of all meetings of the Medical Staff.

11.6.2.6 The Chair of the LMAC will attend all meetings of the Medical Staff, and report on LMAC issues.

11.6.2.7 The business of regular meeting shall inform the Medical Staff of actions recommended by the LMAC.

11.6.2.8 Department/Program and committee reports may be presented at these meetings.

11.6.3 Special Meetings

11.6.3.1 A special meeting of the Medical Staff may be called by the Board of Directors, CEO, President of the Medical Staff, Chair of the HAMAC or at the request of one-third of eligible voting members of Medical Staff and shall be held within ten (10) days of receipt of the request.

11.6.3.2 At a special meeting, no business shall be transacted except as stated in the notice calling the meeting.

11.6.3.3 Notice shall be posted by the President of the Medical Staff at least two (2) days before the special meeting and shall contain the purpose of the meeting.

11.6.3.4 No regular business shall be transacted at a special meeting.

11.6.4 Attendance

11.6.4.1 Active and provisional Medical Staff members shall attend at least 50% of the general Medical Staff meetings in a calendar year.

11.6.5 Quorum

11.6.5.1 At general Medical Staff meetings, a quorum shall consist of 20% of the members of the Medical Staff eligible to vote.

11.6.6 Membership Dues

11.6.6.1 Members of the Medical Staff shall pay annual membership dues at their primary site as applicable for their category. Membership dues shall be determined by a vote at the annual meeting on the recommendation of the elected officers of the Medical Staff.

11.6.6.2 Payment of membership dues is a requirement to retain membership in the Medical Staff, and shall be made

payable within two (2) months following the Annual meeting. Non-payment of dues within the time specified shall be grounds for loss of privileges and/or disciplinary action.

Article 12 – Amendments

Amendments to the IHA Medical Staff Rules shall be made by the HAMAC and approved by the Board of Directors.

12.1 **Review of Medical Staff Rules**

The Rules are reviewed at least every three (3) years, revised as necessary and dated accordingly.

12.2 **Powers of Board**

Notwithstanding anything to the contrary contained herein, the Board may, at any time and from time to time, modify or change these Rules.

12.3 **Authority**

12.3.1 A copy of these Rules shall be forwarded electronically to all members of the Medical Staff, following which the Medical Staff shall be deemed to be informed of them and expected to be compliant with them.

12.3.2 A copy of these Rules signed by the Chair of the IHA Board and the Chair of the HAMAC may be given in evidence in any proceeding within the IHA without any further proof of authenticity.

Article 13 – Approval of the IHA Medical Staff Rules

This is to certify that these Medical Staff Rules were approved by the Board of Directors of the Interior Health Authority at a meeting held on < *Date* >.

Chair, IHA Board of Directors Date of Signature

CEO, IHA Date of Signature

Senior Executive Medical Administrator, IHA Date of Signature

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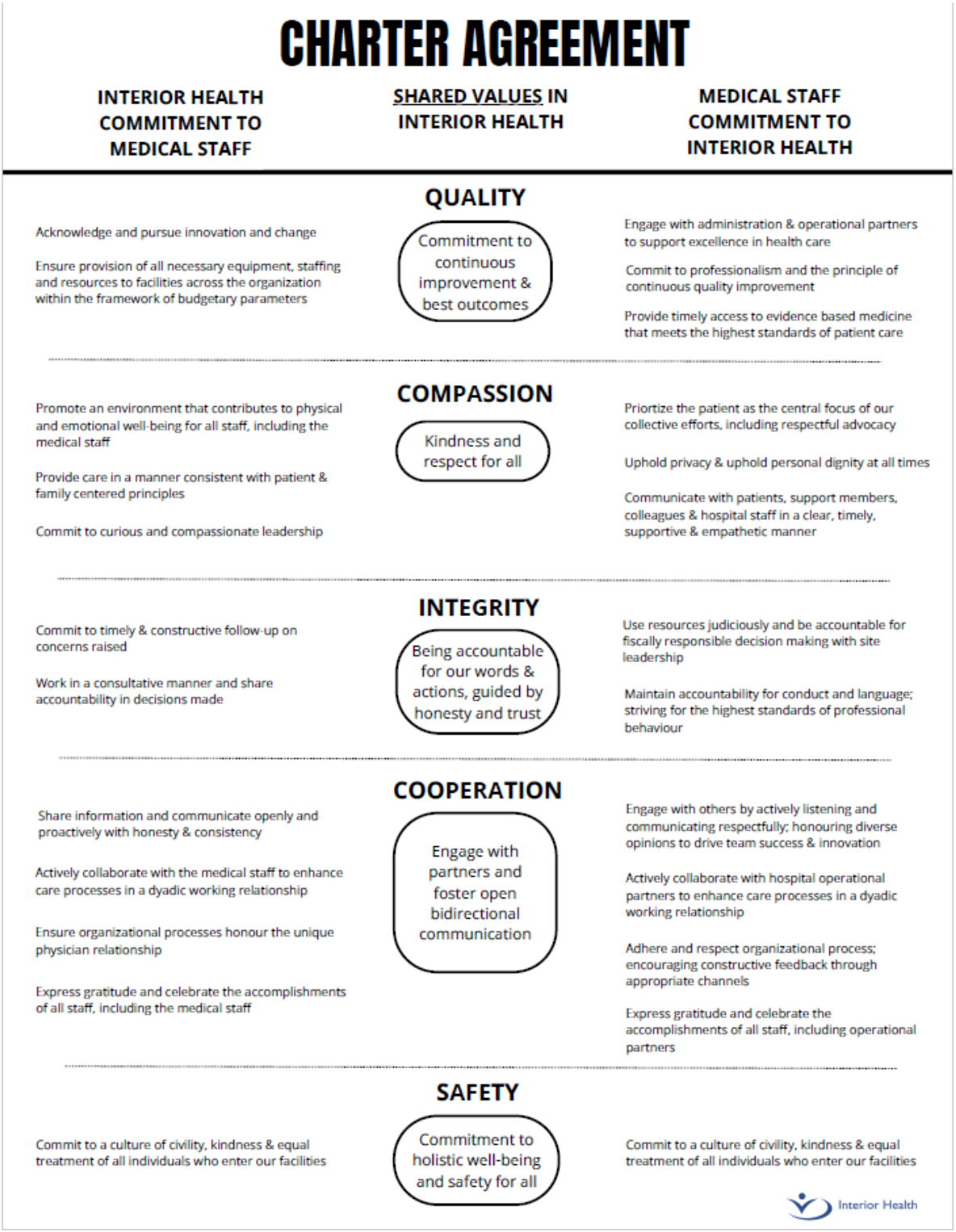
HAMAC Chair, IHA Date of Signature

Appendix A – Interior Health Authority / Medical Staff Charter



CHARTER AGREEMENT

INTERIOR HEALTH COMMITMENT TO MEDICAL STAFF	SHARED VALUES IN INTERIOR HEALTH	MEDICAL STAFF COMMITMENT TO INTERIOR HEALTH
	QUALITY	
Acknowledge and pursue innovation and change Ensure provision of all necessary equipment, staffing and resources to facilities across the organization within the framework of budgetary parameters	Commitment to continuous improvement & best outcomes	Engage with administration & operational partners to support excellence in health care Commit to professionalism and the principle of continuous quality improvement Provide timely access to evidence based medicine that meets the highest standards of patient care
	COMPASSION	
Promote an environment that contributes to physical and emotional well-being for all staff, including the medical staff Provide care in a manner consistent with patient & family centered principles Commit to curious and compassionate leadership	Kindness and respect for all	Priortize the patient as the central focus of our collective efforts, including respectful advocacy Uphold privacy & uphold personal dignity at all times Communicate with patients, support members, colleagues & hospital staff in a clear, timely, supportive & empathetic manner
	INTEGRITY	
Commit to timely & constructive follow-up on concerns raised Work in a consultative manner and share accountability in decisions made	Being accountable for our words & actions, guided by honesty and trust	Use resources judiciously and be accountable for fiscally responsible decision making with site leadership Maintain accountability for conduct and language; striving for the highest standards of professional behaviour
	COOPERATION	
Share information and communicate openly and proactively with honesty & consistency Actively collaborate with the medical staff to enhance care processes in a dyadic working relationship Ensure organizational processes honour the unique physician relationship Express gratitude and celebrate the accomplishments of all staff, including the medical staff	Engage with partners and foster open bidirectional communication	Engage with others by actively listening and communicating respectfully; honouring diverse opinions to drive team success & innovation Actively collaborate with hospital operational partners to enhance care processes in a dyadic working relationship Adhere and respect organizational process; encouraging constructive feedback through appropriate channels Express gratitude and celebrate the accomplishments of all staff, including operational partners
	SAFETY	
Commit to a culture of civility, kindness & equal treatment of all individuals who enter our facilities	Commitment to holistic well-being and safety for all	Commit to a culture of civility, kindness & equal treatment of all individuals who enter our facilities

Interior Health

Appendix B – Interior Health Pharmacy and Therapeutics Committee

1 PREAMBLE

The Interior Health Pharmacy & Therapeutics (IH P&T) Committee is a Standing Committee of the Health Authority Medical Advisory Committee (HAMAC).

2 PURPOSE

The purpose of the IH P&T Committee is to support HAMAC in the following ways:

a) Oversee the IH drug formulary system using an evidence-informed approach to promote appropriate, safe and cost-effective use of medications for IH patients, residents, and clients.

b) Partner with the BC Health Authorities P&T (BCHA P&T) Committee in the development and maintenance of a provincial formulary system;

c) Guide development and implementation programs related to approved formulary changes including education and evaluation;

d) Establish decision support tools for the use of formulary drugs and therapies, (e.g., policies, guidelines, and pre-printed orders);

e) Review and recommend education programs and implementation plans designed to meet the needs of professional staff (physicians, pharmacists, nurses) on matters related to drugs, drug use, drug safety, and related decision support tools.

f) Review medication-related adverse events and quality indicators and to recommend strategies to improve the quality of medication management in IH.

3 COMPOSITION AND TERMS OF OFFICE

3.1 Membership will comprise of 24 voting members:

Medical Staff,	
Regional representation, various disciplines	(12)
Representative, HAMAC	(1)
Senior Medical Director	(non-voting)
Representatives, Nursing	(2)
Representatives, Pharmacy	(6)
Representative, Professional Practice Office	(1)
Director, Quality, Risk, Accreditation	(1)
Director, Pharmacy Services	(1)

3.2 The Medical Staff members will be appointed by HAMAC on the recommendation of the Committee. Physician membership should represent a variety of disciplines and practice settings within IH.

3.3 All Medical Staff members will serve a two-year term and may be re-appointed for two additional terms for a maximum of three consecutive terms.

3.4 Nursing and Professional Practice will be represented by two Nurse delegates and one delegate from the Professional Practice Office.

3.5 Committee membership will not be disclosed to any pharmaceutical company representatives or their employers.

3.6 A staff resource provided by IH Pharmacy Services will be present to serve as Recording Secretary and to assist in the preparing of information required by the committee to discharge its responsibilities.

3.7 Quorum for meetings will be 50% of membership and must include the chair or vice-chair.

4 OFFICERS

4.1 There will be a Chair and Vice Chair who are appointed by HAMAC from among the Medical Staff Members. In making these appointments, the HAMAC may seek counsel from the IH P&T Committee.

4.2 The Chair will be appointed for a term of two years, and may be re-appointed for two additional terms for a maximum of three consecutive terms.

4.3 The Vice-Chair will be appointed for a term of two years and may be re-appointed for two additional terms for a total of three consecutive terms.

4.4 The Director of Pharmacy Services, or designated Pharmacist representative, will serve as the Secretary.

5 EXECUTIVE

The Chair, Vice Chair and Secretary will serve as an Executive. Except as may be otherwise approved by the Committee, the role of the Executive will be as set out in Section 10: Committee Activities

6 CONFLICT OF INTEREST

6.1 Prior to assuming their responsibilities, members of the Committee will formally acknowledge Conflict of Interest Guidelines established by the HAMAC and sign the required disclosure form in a manner and form prescribed by the HAMAC. See Appendix B.

6.2 The obligation to disclose is on-going. Conflict of Interest disclosures must be updated annually, or more frequently as circumstances change.

6.3 When a member recognizes a real or potential conflict of interest, the member should abstain from any related discussion or votes and ensure that the Minutes record that abstention.

6.4 These Conflict-of-Interest Guidelines will similarly apply to any outside parties participating in the affairs of the Committee or in the drug evaluation process.

7 INDEMNITY PROVISIONS & COMPENSATION

7.1 Every committee Member will be indemnified and saved harmless by Interior Health from and against:

a) All costs, charges, and expenses which such Member sustains or incurs in or about any action, suit or proceedings, which is brought, commenced or prosecuted against him or her, or in respect of any act, deed, matter or thing whatsoever, made, done or permitted by him or her, in or about the execution of the duties of such Member or in respect of any such liability;

b) All such other costs, charges, and expenses which he or she sustains or incurs in or about or in relation to the affairs thereof, except such costs, charges or expenses as are occasioned by his or her own willful neglect or default

7.2 Physician members who are not already compensated by IH for administrative work will be compensated, on a sessional basis, for preparation and attendance at Committee meetings. Travel expenses are also covered. See Appendix C.

8 DUTIES AND RESPONSIBILITIES

8.1 Provide input and advice to the BCHA P&T Committee on formulary decisions following consultation with clinical staff and physicians;

8.2 Oversee the development and implementation of decision support tools (including clinical guidelines and pre-printed orders) to promote safe and appropriate drug therapy;

8.3 Guide the implementation of decision support tools to ensure that IH meets established quality and safety standards for managing medications (e.g., Accreditation Canada, College of Pharmacists of BC);

8.3 Establish policies, programs and procedures that help ensure cost-effective use of medications, including therapeutic substitution policies, drug utilization evaluation, and formulary restrictions;

8.4 Monitor quality-assurance activities related to medication management (prescribing, transcribing, dispensing, administering, and monitoring);

8.5 In concert with Local P&T Committees, monitor and evaluate adverse drug events and medication incidents within IH and make recommendations to prevent their occurrence;

8.8 Ensure the development of suitable educational programs for professional staff on matters related to new formulary drugs.

9 SUBCOMMITTEE AND WORK TEAMS

9.1 The Committee will establish and oversee appropriate Subcommittees or Work Teams to advise and do work on behalf of the Committee.

9.2 Subcommittees and Work Teams

9.2.1 **Subcommittees** should be formed when there is an ongoing need for specialized committee work that would be difficult to manage by the IH P&T itself.

Work Teams should be formed when there is a need for a specific body of work that has a defined scope and timeframe.

9.2.2 Terms of Reference for each Subcommittee or Work Team will be reviewed and approved by the Committee.

9.2.3 Membership should foster inter-professional collaboration and adequate regional representation.

9.2.4 Each Subcommittee or Work Team must include a member of the IH P&T Committee.

9.3 Conflict of Interest Declaration

Subcommittees and Work Teams are subject to the same Conflict of Interest disclosure responsibilities as the P&T Committee. See Section 6: Conflict of Interest.

9.4 Accountability and Communication

9.4.1 The Chair, or delegate, of Subcommittees and Work Teams will regularly report activities and progress at IH P&T Committee meetings.

9.4.2 Meeting minutes should be included in the IH P&T Agenda package.

10 COMMITTEE ACTIVITIES

10.1 The Committee will operate in a manner that is consistent with the General Guidelines for Committees of HAMAC; subject only to the provision that there will be four scheduled meetings a year, usually on the third Friday of January, April, June, and October.

10.2 In all major aspects of its mandate, the Committee will endeavor, so far as practical, to involve the Regional Medical Advisory Committees (R-MAC) and the Local Medical Advisory Committees (L-MAC) by:

a) providing relevant Committee motions, information, and background information through electronic distribution.

b) soliciting feedback during the development of initiatives prior to final recommendation to HAMAC;

10.3 The Executive may act for the Committee in addressing urgent issues when a timely meeting of the Committee is not possible or practical. This authority will be limited to (a)urgent patient safety issues or (b)critical administrative issues which can be resolved without benefit of the experience and expertise offered by the full Committee

a) Actions taken by the Executive will be communicated to all members of the Committee and will be put forward for formal approval at the next regular meeting of the Committee.

11 COMMUNICATIONS

11.1 The Committee will assume responsibility for appropriate communication of decisions to all concerned:

a) Agendas will be circulated to Committee members 7 days prior to a duly called meeting.

b) Summary of Motions will be submitted to HAMAC for approval within 7 days of the meeting.

c) Following HAMAC review/approval, the Summary of Motions (including amendments) will be circulated to the Committee members, L-MACs and Local P&T Committees.

d) If stakeholder feedback is being solicited, a letter and feedback form will be distributed to L-MACs, Local P&Ts, and administrative staff under a separate cover.

e) Meeting minutes will be circulated to Committee members with the next Agenda package.

f) A P&T Newsletter will be published following HAMAC review of the motions to broadcast Committee work, decisions, and other related information.

12 REVIEW

The Committee will review these Terms of Reference from time to time and recommend required changes to HAMAC for approval.

Original HAMAC Approval:	December 10, 2004
Most Recent Revision:	October 26, 2012
Regional P&T Approval:	
HAMAC Approved:	

13 ENCLOSURES

IH P and T Appendix A: Nomination process
IH P and T Appendix B: Conflict of Interest Package

IH P and T Appendix A: Nomination Process for Membership in the IH P & T Committee

1.0 Composition

1.1 The Nominating Committee will be composed of the following members:

Chair, HAMAC, or designate

Chair, IH P & T Committee

Regional Director, Pharmacy Services

Senior Medical Director (non-voting)

1.2 A staff resource provided by IH will be present to serve as Recording Secretary and to assist in the development of additional information required by the committee to discharge its responsibilities.

1.3 A quorum for voting will be simple majority of the members eligible to vote.

2.0 Role and Responsibilities

2.1 to receive nominations for appointment;

2.2 to identify potential candidates for appointment;

2.3 to maintain a record of all nominations received; and

2.4 to recommend on request, a slate of candidates to fill declared or expected vacancies.

3.0 Meeting Schedule

The Committee will meet at the call of the Chair when necessary, and as often as necessary, to discharge its responsibilities.

4.0 Nomination Procedures

4.1 P&T will advise the Nominating Committee of all vacancies and anticipated vacancies.

4.2 HAMAC may, at request, or from time to time, propose qualified nominees and will submit to the Nominating Committee a brief written rationale supporting each nomination.

4.3 The Nominating Committee may also propose nominees and will put on the record a short written rationale supporting each such nomination. The name of each nominee, a short *curriculum* vitae, and the supporting rationale will become a part of the permanent records of the Committee and will be available for all Committee deliberations.

4.4 When developing recommendations for candidates to fill vacancies and anticipated vacancies, the Committee will consider:

i) individual qualifications;

ii) expertise/credentials in clinical practice

iii) experience on a previous committee (an asset but is not a requirement)

iv) potential compliance with the Conflict-of-Interest Guidelines

v) availability/commitment of time to participate fully in P&T Committee activities

In making its selection, the Committee will also consider the present make-up of the Committee and the need to maintain a beneficial mix of membership qualifications and background experience.

4.5 The Committee will make its selections by a vote and will submit to HAMAC the name of one recommended candidate for each vacancy identified plus the names of two alternative candidates.

4.6 The submissions to HAMAC will be accompanied by the *curriculum vitae* of each candidate named and the supporting written rationale.

4.7 HAMAC may select any Candidate(s) from among the names submitted by the Nominating Committee and will immediately request that such candidate(s) formally acknowledge the approved Conflict of Interest Guidelines and make any required disclosures.

4.8 HAMAC will make the appointment to the P&T Committee only after it has reviewed the Disclosure Form completed by the candidate(s) and has determined, in its sole discretion, that there is no evidence of any interest or activities which could jeopardize the integrity of the review process.

5.0 Amendment of the Terms of Reference

These Terms of Reference may be amended from time to time, or at any time, by HAMAC after appropriate consultation with the IH P&T Committee.

IH P and T Appendix B: Conflict of Interest Guidelines Governing Members of the Interior Health Pharmacy and Therapeutics Committee, including subcommittees and work teams

1.0 Preamble

The maintenance of the Interior Health (IH) Formulary is an on-going, evidence-informed review of available medications, with consideration given to efficacy, safety, cost, and practicality. The review process requires objective input and must maintain the highest ethical standards, free of conflicts of interest.

In the realities of the relationship between the health care and the pharmaceutical industry, the conflict-of-interest criterion presents a special challenge. Physicians and pharmacists, those who guide the formulary process, are frequently involved in research of new drug products and/or engaged as consultants. They are often provided with honoraria to become speakers and invited to industry-sponsored social and educational opportunities. Importantly, they are universally subjected to the aggressive promotional activities of a highly competitive industry.

In such a setting, the opportunity for conflicts of interest is always present. Equally important, is the perception of those looking on that such conflicts may exist.

This demands that that Members of the IH Pharmacy and Therapeutic Committee (P&T), including its subcommittees or work teams, be governed not only by the broad Standards of the Conduct established by the Board of Directors, but also by more explicit Guidelines in respect to real, potential, or perceived conflicts of interest.

The stringent application of these Guidelines in content and spirit will ensure that conflicts of interest are avoided, thereby preserving both the reliability and credibility of the review process.

2.0 Definitions

"Party" means a drug manufacturer whose product is listed on the IHA formulary or is submitted to the P&T Committee for such listing.

"Participant" means, unless otherwise stated, persons filing a formulary application, the members of the P&T Committee, members of any subcommittees and any experts retained to assist in the drug review process.

3.0 Forms of Conflict of Interest

i) A **real** conflict of interest arises where a Participant, in the review process, has a private or personal interest, for example, a close family connection or financial interest, with a Party.

ii) A **potential** conflict of interest may arise when a Participant, in the review process, has a private or personal interest, such as an identified future commitment, with a Party.

iii) A **perceived** conflict of interest may exist when a reasonable well-informed person has a reasonable belief that a Participant has a conflict of interest, even if there is no real conflict.

4.0 Disclosure Statement

Prior to assuming their responsibilities and annually during the month of April, all persons identified as prospective Participants, by recommendation of the Nominating Committee or by virtue of their role within IHA, must;

i) Sign attached *Form "A",* acknowledging their understanding and acceptance of the Board Policy and these guidelines and, where applicable;

ii)Complete the balance of the *Form "A",* disclosing any known real, potential and possible perceived conflicts of interest as described in the Board's policy, providing relevant details.

5.0 Disqualification

The Chair of the P&T Committee, in consultation with the Chair of the Hospital Authority Medical Advisory Committee (HAMAC), will review all Form "A" disclosure statements and may choose to disqualify any person whose past/current relationship with a Party is such that it may significantly impair that persons' contribution as a Participant.

The facts/relationships of concern will be identified and a person so disqualified may request in writing a review of that decision. If upheld on review, the disqualification will remain in place until such time as evidence has been presented of a significant change in the facts/relationships identified.

6.0 New Developments

The obligation to disclose is on-going and Participants must inform the Chair of P&T at the earliest opportunity of any new development during the course of their continued direct involvement with the committee which might place them in conflict of interest. In such circumstances, the Chair, in consultation with the Chair of HAMAC will have again the authority to determine if, in fact, a conflict of interest exists.

If, in fact, a conflict of interest exists and it cannot be resolved, the person involved may be disqualified as a Participant.

7.0 Specific incidents

There may be occasional, specific instances where a Participant recognizes the potential for conflict of interest. In such circumstances, the Participant should abstain from any related discussion or votes and ensure that the Minutes record that abstention.

8.0 Confidentiality

8.1 The copies of the Guidelines signed by Participants and any disclosures attached thereto will be regarded as confidential and will be properly secured by the Secretary of HAMAC.

8.2 As and when a person ceases to be a Participant, the signed copies of the Guidelines and any disclosures attached thereto will be returned to the individuals involved.

8.3 Participants are expected to respect the confidentiality of any materials provided as part of the review process. No Participant shall knowingly divulge any such information to any person other than another Participant unless the Participant is legally required to do so. A Participant shall not use information obtained as a result of his or her involvement in the review process for his or her personal benefit.

8.4 Each Participant shall avoid activities, which might create appearances that he or she has benefited from confidential information received during the course of his or her activities with the review process.

9.0 General fidelity

These Guidelines will be effective only with the personal respect and commitment of every individual Participant and a continuing collective determination to maintain the integrity of the Formulary process.

10.0 Amendment to Conflict-of-Interest Guidelines

HAMAC may amend these Conflict-of-Interest Guidelines at any time, and from time to time, after appropriate consultation with the Committee Chair.

FORM "A"

CONFIDENTIAL

Conflict of Interest Undertaking

I have read the Board's Policy on Standards of Business Conduct along with the Interior Health P&T Committee's Conflict of Interest Guidelines and understand and agree to be bound by the obligations contained therein.

I have reviewed my activities as they relate to the matters dealt with in the disclosure section of the Guidelines and have:

( ) determined that I have no relevant disclosure to make

( ) completed the attached form to disclose relevant activities

I hereby certify that I have disclosed all relevant information with respect to any matter involving pharmaceutical companies or organizations that may place me in a conflict of interest.

I further promise to inform the Chair of the Interior Health P&T Committee or the subcommittee of any change in circumstances that may create a conflict of interest, as soon as it is known to me.

I agree not to disclose or misuse, in any way, information I may receive in the course of my duties and activities with the review process.

_____

Name

_____

Signature ***Date***

DISCLOSURE FORM

Past/Current Funding

Activities or interests over the past two (2) years involving a pharmaceutical company or related organization:

	YES	NO
▪ Gifts received	( )	( )
▪ Payment to attend or consult at a local function	( )	( )
▪ Travel or Personal Education Funding	( )	( )
▪ Funding or Honoraria for Educational Lectures	( )	( )
▪ Funding or Honoraria for Organizing Conferences	( )	( )
▪ Funding or Honoraria for Writing Articles or Editorials	( )	( )

Please name the Organizations involved: _____

_____

Past Employment

Activities or interests over the past five (5) years involving any pharmaceutical company or related organization:

	YES	*NO*
▪ Employment or payment as Advisor/Consultant	( )	( )
▪ Research Funding or Grants	( )	( )
▪ Academic Appointments (Endowed Chairs)	( )	( )
▪ Educational Training	( )	( )

Please name the Organizations involved: _____

_____

Investment

Significant current investments in pharmaceutical or related organizations, excluding indirect holdings:

- Share holdings ( ) Yes

  Please List: _____

- Options ( ) Yes

  Please List:

  _____

Other activities or interests that might generate a conflict of interest, including relevant activities of a family member or business partner:

_____

Appendix C – Infection Monitoring Prevention and Control Team (IMPACT)

1.0 PURPOSE

The IMPACT makes recommendations regarding the policies and procedures for use within IHA facilities regarding control and prevention of infections

The IMPACT monitors the occurrences of infections as well as the interventions used to limit their occurrences

The IMPACT shall ensure that policies and procedures, which limit the likelihood of an infection being acquired while under the care of the health authority, are written and implemented.

2.0 OBJECTIVES

The IMPACT:

2.1. will receive reports on the frequency and rates of Health Care Associated acquired infections

2.2. will review provincial, national, and international guidelines, and relevant published literature, as appropriate for development of Health Authority policies and procedures in order to ensure best practices are being implemented

2.3. will, following the review (see 2.2), recommend policies and procedures that are effective in increasing the safety of patients, clients and employees

2.4. will develop linkages with provincial bodies such as the Provincial Infection Prevention and Control Network (PICNet)

2.5. will collaborate with Public Health to ensure that prevention strategies are consistent with the strategies used in the community

2.6. will encourage applied research in the area of infection prevention and control within facilities

2.7. will encourage the continuing education of physicians, nurses and other Interior Health staff in infection prevention and control

2.8. will encourage the continuing education of the Infection Prevention and Control Practitioners as well as the Medical Director to ensure best practices are being instituted in Interior Health.

3.0 MEMBERSHIP

- VP Medicine/Quality
- Medical Director, Infection Prevention and Control, (Chair)
- Corporate Director, Infection Prevention and Control
- Manager, Infection Prevention and Control
- Epidemiologist Infection Prevention and Control
- Public Health representative
- Infectious Disease
- Senior Management
- Clinical Microbiology,(Microbiologist from each region)
- Pharmacy
- Workplace Health and Safety representative
- Material Management representative
- Medical Device Reprocessing
- Quality Improvement & Patient Safety representative
- Surgery (surgeon)
- Hospital Administration
- General Practice
- Intensive Care
- Nursing
- Housekeeping
- Residential Care Services
- Chairs of the Regional Infection Prevention and Control Committees (ICCs
- Senior Medical Directors
- Other departmental representatives as required

Medical Appointments to the committee, as noted in the HAMAC Terms of Reference, will be made by HAMAC with no limit to the number of terms an individual physician may serve.

4.0 ACCOUNTABILITY AND REPORTING

The IMPACT will report, via the minutes to the HAMAC, the Senior Executive Team, and to the Board Quality Care Committee.

Bimonthly, an in-person report will be presented to HAMAC

The VP Medicine/Quality is designated as the SET member responsible for the IMPACT

The Infection Monitoring, Prevention And Control Team (IMPACT) is a Standing Committee of the Health Authority Medical Advisory Committee "HAMAC" for Interior Health.

5.0 MEMBER ROLES AND RESPONSIBILITIES

Chair

- Schedule meetings
- Prepare agenda and circulate to membership (Under normal circumstances, the agenda and related material will be distributed to the members not less than one week before the meeting)
- Facilitate meetings

Membership

- All members are free to suggest additions to the agenda
- Attend meetings regularly
- Fully participate in committee activities
- Recommend additions to the agenda – whenever possible, adequate notice should be given to the chair so that there is an opportunity to review the issue and provide background information to the committee members prior to the meeting.

6.0 MEETINGS

- The IMPACT will schedule regular monthly meetings with a minimum of 8 meetings per year or at the call of the Chair. The IMPACT may convene as a quality assurance committee as per Section 51 of the Evidence Act
- The IMPACT may also meet at the call of the Chair to deal with special or urgent issues. In such event, a formal agenda need not be issued. All members will be advised however, of the purpose of the meeting and given adequate notice
- A quorum consists of 51% of the membership. All Members will be voting members and decisions will be made by consensus
- Draft of minutes will be sent to the members of the committee within 2 weeks of the meeting date.

7.0 DISTRIBUTION OF MEETING MINUTES

- Infection Monitoring Prevention and Control Team (IMPACT)
- IH Infection Control (IPAC)
- IH Quality Improvement and Patient Safety (QIPS) Committee
- Medical Microbiologist

8.0 REVIEW OF THE TERMS OF REFERENCE

The committee will review the Terms of Reference every 2 years or more frequently if necessary and recommend any needed changes/additions.

Reviewed and approved by the Infection Monitoring Prevention and Control Team February 7, 2013.

Appendix D – Medical Staff Bylaws and Rules Committee

1.0 Purpose

To review and recommend revisions to *Medical Staff Bylaws*, Rules and policies

2.0 Responsibility

The Medical Staff Bylaws and Rules Committee is responsible to HAMAC

3.0 Composition

The committee membership shall be established by the HAMAC as required for each review process. Membership shall include:

- at least three physician members of the HAMAC
- at least two elected officers of the Medical Staff
- the Senior Medical Administrator (VP Medicine)
- other members of the medical and/or hospital staff as deemed appropriate
- consultants and advisors in a non-voting capacity as deemed appropriate

4.0 Chair

The Chair shall be appointed by the HAMAC for each review process.

5.0 Quorum

A simple majority shall constitute a quorum.

6.0 Meetings

The committee shall meet annually and at the call of the Chair.

7.0 Duties

7.1 To review *Medical Staff Bylaws*, Rules, and policies as requested by the HAMAC

7.2 To review the effects of legislation on the quality of medical care and/or the performance of Medical Staff as requested by the HAMAC

7.3 To seek the advice of experts as deemed necessary by the committee

7.4 To report its findings and recommendations to the HAMAC

Appendix E – Medical Staff Resource Planning Committee

PURPOSE	Review reports regarding human resource requirements to meet the medical, dental, midwifery and nurse practitioner needs of the population served by the Interior Health Authority (IH) and following the review provide advice to HAMAC Assist HAMAC in identifying and supporting planning goals to meet community and population needs within the Interior Health Authority
DEFINITIONS	HAMAC – Health Authority Medical Advisory Committee as described in Article 8 of the Bylaws. IH – Interior Health
SPONSOR	HAMAC
ACCOUNTABLE TO	HAMAC
AUTHORITY	The Medical Staff Human Resource Planning Committee is established by HAMAC consistent with s. 2.2.8 and 8.3.4 of the Medical Staff Bylaws and s. 10.3.3 and 10.13 of the Rules.
APPOINTMENTS	HAMAC
MEMBERSHIP	The Medical Director for Physician Resource Planning and the Corporate Director for Medical Affairs will act as the Co-Chairs: As Co-Chairs: • Schedule meetings, prepare agenda and circulate to membership • At the request of the HAMAC, be present at the HAMAC to discuss all or any part of the MSRP Committee's report • May request a meeting with the HAMAC to discuss a matter arising from the MSRP Committee Membership: • At least three physician members of the HAMAC/Medical Staff (V) • Appropriate representation from Business Support • Other members of the Professional Staff and/or health authority staff as deemed appropriate • Consultants, advisors and administrative staff in a non-voting

	capacity as deemed appropriate • Voting members must be approved by HAMAC
QUORUM & VOTING	a) Quorum constitutes a majority of voting members. b) Where decisions cannot be reached by consensus, motions will require a simple majority of those voting members present in favour to pass.
MEETINGS	a) The Committee shall meet at least five (5) times per year in alternating months and at the call of the Chair. b) Meeting dates and times will be established by the Chair in consultation with the Committee members. c) Minutes shall be kept of the meetings and deliberations and will be organized to ensure confidentiality. d) Minutes will be circulated to all Committee members. e) Minutes, with the exception of those recording *In Camera* business, will be made available to Medical Staff members.
ADMINISTRATION	The Chair shall provide a report to HAMAC on a regular basis. Administrative support shall be provided through the office of the VP Medicine.
SPECIFIC AREAS OF RESPONSIBILITY	PROCESS & PRIORITIES a) Assist in developing methodology for Medical Staff human resource planning that is consistent with Provincial and IH directions. b) Coordinate Medical Staff human resource planning among Departments, Programs, Facilities, and Communities. c) Ensure that Medical Staff human resource planning is congruent with the population health care needs within IH. d) Coordinate Medical Staff human resource planning with IH Clinical Services Plans as developed by regional networks and facilities. e) Ensure Medical Staff human resource planning and recruitment is consistent, where appropriate, with IH's academic mandate to support educational and research activities of learners in the principal four Medical Staff professions.

	ALIGNMENT Develop priority plans and implement transparent decision making processes Ensure effective health human resource planning and management PERFORMANCE Review and make recommendations regarding IH policies, procedures structures and processes for Medical Staff Resource Planning on a yearly basis to ensure process effectiveness and compliance with legislative, regulatory and policy changes STRUCTURES AND COMMUNICATION a) The committee may establish time limited task groups as needed to fulfill its' mandate b) Liaise with other HAMAC, IH, and provincial committees through designated IH leaders c) The Committee will provide advice to HAMAC. HAMAC will submit its' recommendations to the Board of Directors and the Chief Executive Officer for consideration and decision.
DATE APPROVED	
REVIEW DATE	
DIRECT AND INDIRECT LINKAGES	

Appendix F – Credentialing and Privileging Committee

PURPOSE	Advises HAMAC regarding: a) IH policies, procedures and processes for medical staff Credentialing & Privileging b) Individual applications for medical staff appointment, reappointment and change in privileges
DEFINITIONS	Appointment – The process by which a physician, dentist, midwife, or nurse practitioner becomes a member of the medical staff of the Interior Health Authority. Appointment does not constitute employment. BCMQI – British Columbia Medical Quality Initiative is an agency of the Provincial Health services Authority that is responsible for amongst other things the provincial practitioner credentialing and privileging system, regulatory aspects of medical quality and initiatives to improve quality in practice settings. Credentialing – Determination of areas in which medical staff is qualified to practice based on training and experience as per the Provincial Dictionaries and processes. HAMAC – Health Authority Medical Advisory Committee as described in Article 8 of the Bylaws. IH – Interior Health Privileging – Determination within which areas of medical areas of practice an individual is permitted to do – what, where, when, and scope.
SPONSOR	HAMAC
ACCOUNTABLE TO	HAMAC
AUTHORITY	a) The Credentialing & Privileging Committee is established by HAMAC consistent with s. 2.2.6 and 2.2.7 of the Medical Staff Bylaws and s. 10.13 of the Rules. b) The Credentialing & Privileging Committee is established by the Board as "Medical Staff Committee" for the purpose of s. 41(1) of the *Hospital Act* and, as such, meets the definition of "committee" for the purposes of s. 51(I) of the *Evidence Act.*

APPOINTMENTS	Members proposed by Senior Medical Director for Credentialing and Privileging. Members subject to approval by HAMAC - Minimum 1 year appointment, starting in April - Maximum 6 year appointment Reviewed on a yearly basis consistent with s. 10.13 of the Rules.
MEMBERSHIP	The Senior Medical Director for Credentialing & Privileging will act as the Co-Chair with the Coordinator for Credentialing & Privileging. As Chair: • Schedule meetings, prepare agenda and circulate to membership • At request of HAMAC, be present at HAMAC to discuss all or any part of the Credentialing & Privileging Committee's report • May request a meeting with HAMAC to discuss a matter arising from the Credentialing & Privileging Committee Membership: Voting • Senior Medial Director, Credentialing & Privileging (1) • HAMAC Chair (1) • RMAC Chairs (4) Non-Voting • Coordinator, Credentialing & Privileging (1) • Consultants and advisors as deemed appropriate including Aboriginal and patient advisors • Other members of the professional staff and/or Health Authority administrative staff as deemed appropriate
QUORUM & VOTING	A quorum shall consist of a simple majority of voting members. The HAMAC consensus decision-making guidelines will be utilized.
MEETINGS	A minimum of eight meetings per year, further meetings may be called at the discretion of the Chair.
ADMINISTRATION	Administrative support will be provided by the office of the VP Medicine and Quality. Draft minutes from the meeting will be distributed to members in the agenda package of the following meeting. Agenda packages will be distributed no later than 7 days prior to the meeting. At HAMAC's request, minutes will be included in the HAMAC in-camera agenda.

SPECIFIC AREAS OF RESPONSIBILITY	PROCESS & PRIORITIES The Credentialing & Privileging Committee shall: a) Ensure a record of the qualifications and professional career of every member of the professional staff is maintained. b) Ensure that each applicant for appointment to the medical staff meets the criteria as set out in the Bylaws. c) Ensure that each applicant for a change in privileges continues to meet the criteria for re-appointment set out in the Bylaws. d) Consider reports of the interviews with the applicant, where appropriate. e) Consult with the appropriate leader e.g., Department Heads, COS, MAC Chair regarding the application. f) Submit a written report to HAMAC at or before its next regular meeting, setting out the committee recommendations with respect to any application for appointment, re-appointment or change in privileges. The report shall include the kind and extent of privileges requested by the applicant, (Core and Non-Core) and, if necessary, a request that the application be deferred pending further review. ALIGNMENT 4.2 Ensuring effective health human resource planning and management. PERFORMANCE The Credentialing & Privileging Committee shall: a) Review and make recommendations regarding IH policies, procedures, structures and processes for Medical Staff Credentialing & Privileging as needed to ensure process effectiveness and compliance with legislative, regulatory and policy changes. b) Review and make recommendations to HAMAC regarding committee membership on a yearly basis. STRUCTURES AND COMMUNICATION a) The committee may establish time limited task groups as needed to fulfill its mandate. b) Liaise with other HAMAC, IH, and provincial committees through the Chairs. c) Communicate with HAMAC, HAMAC Chair, and VP Medicine & Quality as needed to fulfil its mandate.
DATE APPROVED	HAMAC: JUNE 30, 2022 BOARD:
REVIEW DATE	Next Annual Review: June 30, 2023