Nova Scotia Health Authority
Medical Staff Rules and Regulations
April 1st, 2015
**Preamble**

These Medical Staff Rules and Regulations, together with the Nova Scotia Health Authority (NSHA) Medical Staff Bylaws, govern the activities of the Medical Staff of the NSHA. These Rules and Regulations are made under the authority of and relate to the NSHA Medical Staff Bylaws.

The framework for major matters is set out in the NSHA Medical Staff Bylaws with the details and procedures described in these Rules and Regulations. Additional information regarding operations may be detailed in the rules and regulations, policies and/or Terms of Reference for individual departments, divisions, sections and/or committees.

If there is a conflict between any provisions of these Rules and Regulations and the rules and regulations or policies of a medical department, division, section, or a committee, the provisions of these Rules and Regulations shall prevail.

If there is a non-reconcilable conflict between these Rules and Regulations and the NSHA-Medical Staff by-laws, the provisions of the Medical Staff by-laws shall prevail.

These Rules and Regulations for the Medical Staff shall create a framework within which each member can act with a reasonable degree of independence and confidence. These Rules and Regulations are intended to ensure high quality, safe and consistent patient care at all times.

These Rules and Regulations are effective when the Board of the NSHA approves them.

Words and terms not otherwise defined in these Rules and Regulations shall have the same definition as is outlined in the NSHA – Medical Staff By-laws.

**1.0 Medical Staff Responsibilities**

**1.0.1 All Medical Staff shall:**

- care for patients regardless of race/ethnicity, nationality, religion, sexual orientation, gender identification and/or expression and disability, and shall seek to assist all patients in obtaining appropriate care

- adhere to and comply with all NSHA policies and procedures, Medical Staff Bylaws and these Rules and Regulations

- provide the highest quality care possible to all patients in a compassionate and collaborative manner

- provide instruction, as required, to other members of the medical staff and all members of the interdisciplinary health care team;

- serve on any committees appointed to by the HAMAC, ZMAC, the ZMSA, Zone Executive Medical Director or the VP Medicine Integrated Health Services
• maintain competence in their field of practice through a program of continuing education as may be specifically required and communicated by the applicable Zone Department or Division Head and as stipulated below:
  • For registered specialists, follow the guidelines for hours of continuing medical education (CME) as per the Royal College of Physicians and Surgeons of Canada.
  • For Family Physicians, follow the CME guidelines per the College of Family Physicians of Canada.
  • For dentists, follow the Continuing Dental Education Guidelines as mandated by the Provincial Dental Board of Nova Scotia

• regulate their activities with respect to care, treatment and operative procedures in accordance with the type and degree of privileges granted them by the Board

• create a respectful environment for all patients and their families, colleagues and peers

1.0.2 Every member of the Medical Staff, in order to provide the best possible care within the available resources, shall work cooperatively with all colleagues and with NSHA Leaders

2.0 Admission of Patients to NSHA Facility:

2.0.1 A Member of the Medical Staff and other persons specifically defined in the NSHA’s policies and procedures:

  • may admit to an NSHA facility provided he/she has Active with Admitting privileges or has otherwise be granted authority to admit patients under the NSHA’s policies, procedures and by-laws. Each member of the medical staff and other persons with authority to admit patients and must abide by the policies and bed allocation procedures of the NSHA.

  • who recommends the admission to a NSHA facility shall provide the information necessary to determine the appropriate accommodation for care of the patient. If the person recommended for admission presents a danger to himself or other persons, the physician or dentist who recommended admission should provide sufficient information to allow the NSHA to determine any measures to be taken to protect the safety of the patient or other persons.

3.0 Attendance to Patients in an NSHA Facility

• The medical care of each patient admitted to NSHA health care facility shall be provided or supervised by the patient’s most responsible provider who is a member of the Medical Staff or other person who is provided with such authority under NSHA’s policies and procedures. Such most responsible provider has overall responsibility for the patient’s
medical care and shall be identified in the patient’s health record as the most responsible health care provider and shall identify her/himself to the patient.

- The patient’s most responsible provider or his/her authorized delegate, shall examine the patient within twenty-four (24) hours after the patient is admitted.

- If the medical care of the patient is transferred to another most responsible provider, the provider making the transfer shall abide by any established departmental policies concerning the routine transfer of patient care. If no such policies exist, the provider making the transfer shall directly notify the receiving most responsible provider or their authorized delegate of the transfer, and shall notify the patient.

4.0 History and Physical Documentation Standards for patients in an NSHA Facility

- Within twenty-four (24) hours of a patient’s admission, the most responsible provider or his/her authorized delegate, shall complete, date and sign a history and physical examination in the patient’s health record. The history and physical examination shall include the presenting complaint(s), the history of the present illness, a functional enquiry, appropriate personal and family history, the physical examination and a provisional diagnosis. If the patient has been readmitted within thirty (30) days of discharge with the same diagnosis, the documentation of the examination should reflect the changes since the last admission.

- If a history and physical examination report for the patient that was completed by a NSHA most responsible provider within the previous six (6) months is available, that report may be accepted as the required history and physical examination documentation, provided the most responsible provider confirms in her/his notation that it reflects the patient’s current health status and reason for current admission.

- If a patient is admitted for same day admission or outpatient medical procedure, the most responsible provider who intends to perform the procedure shall write, date and sign a notation in the patient’s health record confirming the history and physical examination report reflects the patient’s current health status and the reasons for the proposed procedure.

- No history and physical examination report completed by an undergraduate student or other unauthorized health professional is valid until it is countersigned by the patient’s most responsible provider or their authorized delegate.

- Medical Staff Progress Notes must include a date, time, printed name of physician, and signature. They shall be written as the events occur and shall give a pertinent chronological report of the patient’s course. These shall be sufficient to describe changes in the patient’s condition, the outcome of the treatment, and discharge planning. Not only is it important
to note in the record when the patient starts to have problems, but also document when they are doing well, as this helps to define the course of their clinical recovery

- For acute care patients, the progress notes must be written at least daily during a serious illness and at least twice weekly for patients receiving routine care. For long term care patients, the notes must be recorded as events occur during the patient’s care. If the patient is given any patient education, a notation must be recorded in the progress notes, or elsewhere as appropriate

- All patients must be asked if they have any allergies and the most responsible provider shall write, date and sign a notation in the patient’s health record, including the identification of the allergy and the nature of the reaction.

5.0 Medical and Surgical Procedures

- Before any patient undergoes any medical/surgical procedure, the most responsible provider who intends to perform the procedure shall write, date and sign a notation in the patient’s health record confirming the pertinent history and physical examination and the reasons for the proposed procedure.

- Within twenty-four (24) hours of completing each medical/surgical procedure, the most responsible provider or their authorized delegate who performs the procedure shall write or dictate a report of the procedure which includes the full details of the technique, findings and any complications. The person who writes/dictates the report shall date and sign it. The report must be filed in the patient’s health record.

- When dictated reports will require a period of turnaround time, a hand-written note should be placed on the chart immediately following the medical or surgical procedure(s) summarizing any important findings or recommendations in sufficient details to enable a designate to safely manage the care of the patient.

6.0 Tissue Examination

Pursuant to the regulations made under the Nova Scotia – Hospitals Act, all tissue or foreign material that is removed during a medical/surgical procedure shall be sent to the Department of Pathology and Laboratory Medicine. The pathologist shall make any examination he/she considers necessary, and write, date and sign a pathology report describing the results of the examination. The report must be filed in the patient’s health record. Exemptions from the above include ocular lenses, teeth, organs and tissues removed for transplantation and determined to be unsuitable.
7.0 **Medical Staff Orders**

- Ordinarily, all orders for treatment must be in writing. A member of the medical staff, or his/her delegate, may in exceptional circumstances based on the urgency of the need for an order to provide patient care, give a verbal order to a registered nurse who shall write, date and sign the order in the patient’s health record with the name of the medical staff member documented. The Most Responsible Provider or delegate shall date and sign the order as soon as possible, and on inpatient units within twenty-four (24) hours.

- No order written by an undergraduate medical or dental student is valid as a medical staff order until it is countersigned by a physician or dentist or his/her physician or dentist delegate.

8.0 **Transfer Notes**

When a patient is to be transferred from one service to another, or from one health care facility to another or discharged from a health care facility of NSHA and a completed discharge summary report is not available, the patient’s most responsible provider or their authorized delegate shall at that time complete, date and sign an interim discharge report. The report must contain appropriate information to enable the patient’s family physician, dentist or other primary care provider/practitioner to provide follow-up care of the patient. The report must be filed in the patient’s health record and a copy must be sent to the patient’s family physician or dentist.

9.0 **Completion of Medical Records**

For the purposes of this section where a specific date is mentioned should that date fall on a holiday or weekend the next working day will be used.

All charts should be completed as soon as possible after the discharge.

On the 15th day of each month, the NSHA’s Health Records Department will count the uncompleted charts for each member of the Medical Staff and will notify those medical Staff members by letter. This letter shall be taken as a “notice to complete”. On the 30th day of each month, the Health Records department will count those charts which are still not complete, and will notify the CEO or designate. The CEO or designate will send a letter notifying the medical staff member of such outstanding charts and will give 10 working days’ notice for completion of the charts.

9.0.1 **Temporary reduction of privileges**

Subject to Sections 1, at the end of the grace period which expires 10 working days following the second notice letter provided under section 9.0, any member of the medical
staff who has not yet completed those charts shall without further notice have their privileges reduced by the CEO or the VP Medicine or designate. During this period, the physician must make arrangements for a medical staff colleague on their behalf to a) continue and complete the treatment of any patients already admitted, b) honour any on-call commitments and c) attend any necessary patient admissions.

(1) The CEO or VP Medicine may delay or modify the imposition of any reduction of privileges if such a reduction might adversely affect in a material way the services provided to the public by the facility.

9.0.2 Notification

The medical staff members whose privileges have been reduced pursuant to 9.0.1 shall be notified in writing by the office of the VP Medicine, Integrated Health Services or through other reasonable attempts at the discretion of the VP Medicine Integrated Health Services, including but not limited to leaving a message on the voice mail for the affected member of the medical staff by phone will also be made. The Admitting Dept., Emergency Dept., and Operating Room Supervisor, Utilization Dept, Site Coordinator, and Department Head shall also be informed.

9.0.3 Reinstatement

The CEO, VP Medicine or designate shall reinstate the privileges that were reduced as soon as possible after notification by the Health records Dept that the charts have been completed, the non-completion of which resulted in the privileges alteration.

10.0 Autopsies

- In accordance with the educational mission of NSHA, unless the autopsy policy states otherwise, when a patient in a health care facility of NSHA dies, if in the opinion of the most responsible member of the medical staff or their authorized delegate there may be a medical or educational benefit in completing an autopsy, the most responsible medical staff members or their authorized delegate shall seek consent to perform an autopsy including the extent of the autopsy, from the individual legally responsible for the remains of the patient who has died.

- Autopsies may also occur at the request of the family in which case consent still needs to be obtained.

- The member of the Medical Staff who obtains the consent shall document the consent in writing and sign it on the approved NSHA form. The requirements and procedures for obtaining and documenting informed consent are set out in NSHA policies. The completed consent form must be filed in the patient’s health record. Any NSHA policies or procedures
applicable to autopsies including but not limited to obtaining consent for autopsies apply as if recreated in these by-laws.

11.0 Organ Donation Screening and Consent

- All members of the Medical Staff shall comply with the provisions of the NSHA’s Organ Tissue Donation policies.

12.0 Terms of Reference for HA-MAC and ZMAC Committees

The terms of reference for all HA-MAC Committees shall be as set forth in the NSHA- Medical Staff by-laws or if not so stipulated in the by-laws shall be the terms of reference as are set forth below.

(Note as of October 2015) These committees are still in the process of being formed