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This document is ***not*** the official version of these regulations. The regulations and the amendments printed in the ***Royal Gazette*** should be consulted to determine the authoritative text of these regulations.

For more information concerning the history of these regulations, please see the ***Table of Regulations***.

If you find any errors or omissions in this consolidation, please contact:

Legislative Counsel Office
Tel: (902) 368-4291
Email: legislation@gov.pe.ca

CHAPTER H-10.1

HOSPITALS ACT

HOSPITAL MANAGEMENT REGULATIONS

Pursuant to section 11 of the *Hospitals Act* R.S.P.E.I. 1988, Cap. H-10.1, Council made the following regulations:

INTERPRETATION

1. (1) In these regulations — Definitions

(a) "Act" means the *Hospitals Act* R.S.P.E.I. 1988, Cap. H-10.1; — Act

(b) "admitted" means, in respect of a hospital, registered at the hospital as an in-patient and provided with accommodation in the hospital; — admitted

(c) "anaesthetist" means a member of the medical staff with privileges at a hospital who administers an anaesthetic to a patient at the hospital; — anaesthetist

(d) "attending dental practitioner" means a dental practitioner who is a member of the medical staff with privileges at a hospital and has principal responsibility for the dental care of a patient at the hospital; — attending dental practitioner

(e) "attending medical practitioner" means a medical practitioner who is a member of the medical staff with privileges at a hospital and has principal responsibility for the medical care of a patient at the hospital; — attending medical practitioner

(f) "attending oral and maxillofacial surgeon" means an oral and maxillofacial surgeon who is a member of the medical staff with privileges at a hospital and has principal responsibility for the dental or medical care of a patient at the hospital; — attending oral and maxillofacial surgeon

(g) "attending practitioner" means an attending dental practitioner, an attending medical practitioner, or an attending oral and maxillofacial surgeon; — attending practitioner

(h) "birth" means the complete expulsion or extraction from its mother of a foetus which did at any time after being completely expelled or extracted from the mother breathe or show any other sign of life, whether or not the umbilical cord was cut or the placenta attached; — birth

(i) "Board" means the Board of Directors of Health PEI; — Board

communicable disease

(j) "communicable disease" means a communicable disease as defined in the *Public Health Act* R.S.P.E.I. 1988, Cap. P-30;

dental practitioner

(k) "dental practitioner" means a person who is lawfully entitled to practise dentistry in the province under the *Dental Profession Act* R.S.P.E.I. 1988, Cap. D-6;

health number

(l) "health number" means a health number as defined in the *Provincial Health Number Act* R.S.P.E.I. 1988, Cap. P-27.01;

Health PEI

(m) "Health PEI" means Health PEI as defined in the *Health Services Act* R.S.P.E.I. 1988, Cap. H-1.6;

health record

(n) "health record" means any written, printed, photographic or electronic record pertaining to a patient at a hospital;

in-patient

(o) "in-patient" means a person who is admitted to a hospital;

medical director

(p) "medical director" means, in respect of a hospital, the medical practitioner who is appointed as the medical director of the hospital under the bylaws of Health PEI;

medical practitioner

(q) "medical practitioner" means a person who is lawfully entitled to practise medicine in the province under the *Medical Act* R.S.P.E.I. 1988, Cap. M-5;

medical record

(r) "medical record" means a record compiled under subsection 16(2) or (3);

medical staff

(s) "medical staff" means the medical practitioners, dental practitioners and nurse practitioners who are appointed by the Board to the medical staff of Health PEI;

nurse practitioner

(t) "nurse practitioner" means a registered nurse who is lawfully entitled to engage in the practice of a nurse practitioner under the *Registered Nurses Act* R.S.P.E.I. 1988, Cap. R-8.1;

oral and maxillofacial surgeon

(u) "oral and maxillofacial surgeon" means a dental practitioner who is lawfully entitled to practise the specialty of oral and maxillofacial surgery in the province under the *Dental Profession Act*;

out-patient

(v) "out-patient" means a person who is registered as an out-patient at a hospital;

patient

(w) "patient" means an in-patient or an out-patient;

photograph

(x) "photograph" means a reproduction made by any process that makes an exact image of the original and includes any photographic plate, microphotographic film, photostatic negative, autopositive and any photographic print made therefrom;

(y) "privileges" means, in relation to a hospital, the authority granted by the Board, under the bylaws of Health PEI**,** to a member of the medical staff to

(i) order the admission of persons to the hospital,

(ii) treat or order the treatment of patients at the hospital, and

(iii) order the discharge of in-patients at the hospital;

privileges

(z) "registered nurse" means a person who is legally entitled to engage in the practice of a registered nurse under the *Registered Nurses Act*;

registered nurse

(aa) "surgeon" means a member of the medical staff with privileges at a hospital who performs a surgical operation on a patient at the hospital.

surgeon

(2) Nothing in these regulations authorizes a member of the medical staff to do anything at a hospital that the member is not authorized to do under the applicable Act governing his or her profession or in accordance with his or her privileges. (EC49/11)

No authorization granted to exceed privileges or Act governing profession

MANAGEMENT

2. (1) Health PEI is responsible for the operation of all hospitals in the province.

Operation of hospitals

(2) The Board shall appoint an administrator to manage the day to day operations of a hospital.

Administrator

(3) Every administrator is responsible to the Board for taking such action as the administrator considers necessary to ensure compliance with the Act, these regulations and any bylaws or policies of Health PEI that apply to hospitals.

Duties of administrator

(4) A person who, immediately before the day these regulations come into force, is employed as the administrator of a hospital, is deemed to have been appointed under subsection (2) as the administrator of the hospital, until the appointment is revoked or the person resigns. (EC49/11)

Continuation as administrator

ADMISSION

3. (1) No person shall be admitted to a hospital except on the order of a medical practitioner or an oral and maxillofacial surgeon, who is a member of the medical staff with privileges at the hospital.

Authority to admit

(2) No medical practitioner or oral and maxillofacial surgeon shall order the admission of a person to a hospital unless, in the opinion of the

No admission unless clinically necessary

medical practitioner or oral and maxillofacial surgeon, it is clinically necessary that the person be admitted.

Deemed admission on birth

(3) Notwithstanding subsections (1) and (2), a baby born alive in a hospital shall be deemed to have been admitted to the hospital at the time of birth. (EC49/11)

Register number

4. (1) The administrator of a hospital shall ensure that each person who is admitted to the hospital is assigned a unique register number.

Register

(2) The administrator of a hospital shall ensure that a register is kept for the hospital in which the following information is recorded in respect of each in-patient:

(a) the register number assigned to the in-patient under subsection (1);
(b) the health number of the in-patient;
(c) the name, gender and age of the in-patient;
(d) the date of admission of the in-patient;
(e) the name of the attending practitioner of the in-patient;
(f) the diagnosis of the attending practitioner on the admission of the in-patient;
(g) the date of the discharge or death of the in-patient.

Use throughout admission

(3) The administrator of a hospital shall ensure that an in-patient is identified in any document that forms part of the medical record of the in-patient and on the medical record itself by the register number assigned under subsection (1) until the in-patient is discharged from the hospital. (EC49/11)

Emergency contact

5. The administrator of a hospital shall ensure that when a person is admitted to the hospital, the name and contact information of an emergency contact for the person is requested. (EC49/11)

PATIENT CARE

Medical care on admission

6. (1) Within twenty-four hours after the admission of an in-patient for medical treatment, the attending medical practitioner shall

(a) record a medical history of the patient;
(b) make a physical examination of the patient and record his or her findings;
(c) make and record a provisional diagnosis of the patient's medical condition; and
(d) make and record a proposed plan of medical treatment for the patient.

(2) Within twenty-four hours after the admission of an in-patient for dental treatment, the attending dental practitioner or the attending oral and maxillofacial surgeon shall

Dental care on admission

(a) record a dental history relative to the treatment;

(b) make a dental and oral examination of the patient and record his findings;

(c) make and record a provisional diagnosis of the patient's dental condition; and

(d) make and record a proposed plan of dental treatment for the patient.

(3) Where a patient is admitted for an oral and maxillofacial surgical operation, the attending oral and maxillofacial surgeon shall comply with subsections (1) and (2) with respect to the patient before beginning the surgical operation. (EC49/11)

Admission for dental surgery

7. (1) No person shall order treatment at a hospital for a patient except

Authority to order treatment

(a) the attending practitioner of the patient; or

(b) a member of the medical staff with privileges at the hospital who is authorized by the attending practitioner of the patient to order treatment for the patient.

(2) Where the attending practitioner of a patient is unable for any reason to perform his or her professional duties with respect to the patient, the attending practitioner shall transfer principal responsibility for the care of the patient to another member of the medical staff with appropriate skills and privileges. (EC49/11)

Transfer of responsibility

INFECTION CONTROL

8. (1) The administrator of a hospital shall provide for the isolation of patients in the hospital who have a communicable disease.

Isolation wards

(2) The attending practitioner of a patient shall cause the patient to be isolated from other patients if the attending practitioner knows the patient is or suspects that the patient may be infected with a communicable disease. (EC49/11)

Isolation if communicable disease

ANAESTHESIA

9. (1) No anaesthetist shall administer an anaesthetic to a patient unless the following information has first been entered in the medical record of the patient:

Information required before anaesthesia

(a) a history of the present and any previous illnesses of the patient;

(b) the results of any diagnostic tests that the attending practitioner of the patient considers essential to the proper assessment of the patient's physical condition;

(c) the findings of the attending practitioner after making a physical examination of the patient.

Duties of anaesthetist

(2) No anaesthetist shall administer an anaesthetic to a patient unless the anaesthetist has first

(a) taken a medical history and made a physical examination of the patient sufficient to enable the anaesthetist to evaluate the physical condition of the patient and to choose a suitable anaesthetic for the patient; and

(b) entered or caused to be entered on the anaesthetic record compiled in accordance with subsection (5), data from the medical history, laboratory findings and physical examination of the patient that is relevant to administering the anaesthetic.

Emergencies

(3) Subsections (1) and (2) do not apply where the anaesthetist and the surgeon who is to operate on the patient are of the opinion that a delay for the purpose of complying with those subsections would endanger the patient.

Reasons for non-compliance

(4) Where an anaesthetist administers an anaesthetic to a patient without complying with subsection (1) or (2), in accordance with subsection (3), the anaesthetist and the surgeon who operated on the patient shall prepare or cause to be prepared in writing and sign a statement of the reasons for non-compliance, which the administrator shall ensure is included the patient's medical record.

Anaesthetic record

(5) An anaesthetist shall prepare or cause to be prepared in writing and sign an anaesthetic record with respect to a patient to whom he or she administers an anaesthetic, which includes

(a) the medications given to the patient in contemplation of anaesthesia;

(b) the anaesthetic agents used, methods of administration of such agents and the proportions or concentrations of all agents administered to the patient by inhalation;

(c) the names and quantities of all drugs given to the patient by injection;

(d) the duration of the anaesthesia on the patient;

(e) the quantities and type of all blood products and other fluids administered intravenously to the patient during the operation;

(f) the estimated fluid loss of the patient during anaesthesia; and

(g) the vital signs of the patient before, during and after the anaesthesia.

(6) Every anaesthetist who administers an anaesthetic to a patient is responsible for directing the post-anaesthetic care of the patient. (EC49/11) Post-anaesthetic care

SURGICAL OPERATIONS

10. (1) No surgeon shall perform a surgical operation on a patient unless the surgeon first Examination prior to surgery

(a) performs a physical examination of the patient sufficient to enable the surgeon to make a diagnosis; and

(b) enters or causes to be entered on the medical record of the patient a signed statement of his or her findings on the physical examination and a diagnosis.

(2) Every surgeon who performs a surgical operation in a hospital shall prepare or cause to be prepared, in writing, and sign a description of the operative procedure and any findings or diagnosis resulting from the operation with respect to the patient. Surgical report

(3) The surgeon who performs a surgical operation on a patient is responsible for directing the post-operative care of the patient until the responsibility for care of the patient is assumed by another member of the medical staff with privileges at the hospital. (EC49/11) Post-operative care

11. (1) A surgeon shall not dispose of any tissues removed from a patient during a surgical operation or curettage. Disposal of tissue

(2) The administrator of a hospital shall ensure that all tissues removed from a patient during a surgical operation or curettage carried out at the hospital, together with adequate clinical data, are sent to a pathologist for examination and report. Tissue sent to pathologist

(3) Notwithstanding subsection (1) and (2), Health PEI may, with the advice of the medical staff, establish policies authorizing the disposal of specified types of tissue without an examination and report by a pathologist. Exception

(4) Where tissues and clinical data are sent to a pathologist in accordance with subsection (2), the pathologist shall conduct an examination of the tissues and prepare or cause to be prepared in writing and sign a report of his or her findings. Pathology examination and report

(5) The administrator of a hospital shall ensure that a copy of a report prepared by a pathologist under subsection (4) in respect of any tissue removed at the hospital from a patient is Distribution of pathology report

(a) included in the medical record of the patient;

(b) provided to the surgeon who removed the tissue; and

(c) provided to the family medical practitioner of the patient. (EC49/11)

DISCHARGE

12. (1) In this section

attending medical practitioner

(a) "attending medical practitioner" includes a member of the medical staff with privileges at the hospital who is authorized by the attending medical practitioner of an in-patient to discharge the in-patient;

attending oral and maxillofacial surgeon

(b) "attending oral and maxillofacial surgeon" includes a member of the medical staff with privileges at the hospital who is authorized by the attending oral and maxillofacial surgeon of an in-patient to discharge the in-patient;

medical director

(c) "medical director" includes a medical practitioner who is a member of the medical staff with privileges at the hospital who is authorized by the medical director to

(i) perform the duties of a medical director under subsection (5) with respect to an in-patient or group of in-patients, or

(ii) order the discharge of an in-patient under subsection (6).

Authority to discharge

(2) No person shall order the discharge of an in-patient from a hospital except

(a) the attending medical practitioner or attending oral and maxillofacial surgeon of the in-patient; or

(b) the medical director.

Mandatory discharge

(3) Subject to subsection (4), where

(a) in the opinion of the attending medical practitioner or attending oral and maxillofacial surgeon of an in-patient, as the case may be,

(i) it is no longer clinically necessary for an in-patient to be admitted to a hospital, or

(ii) it is necessary or more appropriate for the in-patient to be transferred to another hospital for treatment;

(b) an in-patient discharges himself or herself from the hospital; or

(c) an in-patient dies while admitted to the hospital,

the attending medical practitioner or attending oral and maxillofacial surgeon, as the case may be, shall

(d) make an order to discharge the in-patient from the hospital; and

(e) communicate or cause the order to be communicated to the in-patient, where appropriate.

(4) The attending medical practitioner or attending oral and maxillofacial surgeon of an in-patient, as the case may be, may delay making an order to discharge an in-patient under subsection (3) Delay

(a) until accommodation becomes available for the in-patient in another hospital or a residential care facility, where the in-patient is awaiting transfer to that other hospital or residential care facility; or

(b) until home care services or other community-based support services are available to the in-patient, where the in-patient is awaiting such services.

(5) The medical director of the hospital shall review the clinical status of an in-patient at least once every seven days following admission of the in-patient until the in-patient is discharged. Review of clinical status

(6) Upon reviewing the clinical status of an in-patient under subsection (5), the medical director may Discharge by medical director

(a) make an order to discharge the in-patient from the hospital; and

(b) communicate or cause the order to be communicated to the in-patient,

if

(c) in the opinion of the medical director,

(i) it is no longer clinically necessary for an in-patient to be admitted to a hospital, or

(ii) it is necessary or more appropriate for the in-patient to be transferred to another hospital for treatment; and

(d) subsection (4) does not apply.

(7) Where an order to discharge an in-patient is made under this section, the administrator shall ensure that the in-patient is discharged and leaves the hospital within twenty-four hours of the date the order to discharge was made. (EC49/11) Administrator to ensure discharge is effected

13. (1) The person who was the attending practitioner of an in-patient immediately prior to the discharge or death of the patient shall prepare or cause to be prepared a written discharge summary of the medical record of the patient within 48 hours after the discharge or the death of the patient. Discharge summary

(2) A member of the medical staff who was involved in the care of an in-patient at any time while the in-patient was admitted to the hospital shall, within seven days after the discharge or the death of the in-patient, complete all of the records in relation to the patient that he or she is required to complete under these regulations. Records to be completed

(3) The Board or a person designated by the Board may suspend the privileges of any member of the medical staff who fails to comply with Suspension

subsection (1) or (2) until the member of the medical staff so complies. (EC49/11)

Post mortem report

14. Where a medical practitioner performs a *post mortem* examination on the body of a patient, the medical practitioner shall, as soon as is reasonably possible afterwards, prepare or cause to be prepared in writing and sign a report of the examination. (EC49/11)

ORDERS

Orders to be written and signed

15. (1) A person who makes an order for the admission, treatment or discharge of a patient under these regulations shall make such order in writing and date and sign the order.

Dictation of order

(2) Notwithstanding subsection (1), a person who makes an order for the admission, treatment or discharge of a patient under these regulations may dictate the order orally to a person authorized by the administrator to take such orders.

Transcription of order

(3) The person to whom an order has been dictated under subsection (2) shall transcribe and sign the order and endorse thereon the name of the person who dictated the order and the date and time of receiving the order.

Dictated order to be signed

(4) A person who has dictated an order orally under subsection (3) shall sign the order when he or she next attends the hospital. (EC49/11)

RECORDS

Health records

16. (1) The administrator of a hospital shall ensure that a system is established for the compiling and keeping of health records for each patient.

Inpatient medical record

(2) The administrator of a hospital shall ensure that a medical record is compiled for each in-patient, from the time of admission to the time of discharge, which shall include

(a) patient identification;
(b) the names of the attending practitioners of the in-patient;
(c) the health history of the in-patient;
(d) all records of treatment received by the in-patient;
(e) all provisional and final diagnoses of the in-patient;
(f) all orders for treatment of the in-patient;
(g) all consents to treatment obtained in writing with respect to the in-patient;
(h) chart notes and measurements of the temperature, blood pressure, respiration, vital signs and fluid balances of the in-patient;
(i) all reports prepared by the medical staff respecting the in-patient;

(j) the order for discharge and the discharge summary of the in-patient; and
(k) a copy of the death certificate of the in-patient, where the in-patient dies in the hospital.

Out-patient medical record emergency

(3) The administrator of a hospital shall ensure that a medical record is compiled for each out-patient, for each visit to an emergency or urgent care department at the hospital, which shall include
(a) patient identification;
(b) the names of the attending practitioners of the out-patient;
(c) the health history of the out-patient;
(d) all records of treatment carried out on the out-patient;
(e) all provisional and final diagnoses of the out-patient;
(f) all orders for treatment of the out-patient;
(g) all consents to treatment obtained in writing with respect to the out-patient;
(h) chart notes and any measurements of the temperature, blood pressure, respiration, or vital signs of the out-patient; and
(i) any reports prepared by the medical staff respecting the out-patient.

Out-patient health record - treatment

(4) The administrator of a hospital shall ensure that health records are maintained for each out-patient who attends the hospital for scheduled treatment, which shall include
(a) all orders for the treatment of the out-patient;
(b) any consents to treatment obtained in writing with respect to the out-patient; and
(c) all records of the treatment carried out on the out-patient.

Health number

(5) The administrator of a hospital shall ensure that all health records of a patient bear the patient's health number. (EC49/11)

Safe and secure storage

17. (1) The administrator of a hospital shall ensure that all health records are safely and securely stored.

Format of records

(2) The administrator of a hospital may provide for the storage of health records in any format that enables the information in the health records to be retrieved and utilized, in accordance with the policies of Health PEI. (EC49/11)

Retention policies

18. (1) Health PEI shall ensure that retention policies and schedules, consistent with the Act and these regulations are established for health records.

Retention of medical records

(2) Subject to subsections (3) and (4), the administrator of a hospital shall ensure that a medical record of a patient is retained
(a) in the case of a patient who is eighteen years of age or older, for

(i) at least twenty years after the date of discharge from the admission or the date of the outpatient visit of the patient to which the record relates, or

(ii) where the patient has died, at least five years after the death of the patient; and

(b) in the case of a patient who is under eighteen years of age, for

(i) at least twenty years after the eighteenth anniversary of the birth of the patient, or

(ii) where the patient has died, at least five years after the death of the patient.

Diagnostic imaging record

(3) The administrator of a hospital shall ensure that a diagnostic imaging record, other than a diagnostic imaging examination of the breast, is retained

(a) in the case of a patient who is eighteen years of age or older, for at least five years after the date on which the diagnostic imaging record is created; and

(b) in the case of a patient who is under eighteen years of age, for at least five years after the eighteenth anniversary of the birth of the patient.

Diagnostic imaging record of breast

(4) The administrator of a hospital shall ensure that a diagnostic imaging record examining the breast, is retained

(a) in the case of a patient who is eighteen years of age or older, for at least ten years after the date on which the diagnostic imaging record is created; and

(b) in the case of a patient who is under eighteen years of age, for at least ten years after the eighteenth anniversary of the birth of the patient.

Exception

(5) Notwithstanding subsections (1) to (4), if, before the end of a retention period established under subsection (1) or referred to in subsections (2) to (4), Health PEI receives notice of a court action, investigation, assessment, inspection, inquest or other inquiry relating to care received by a patient, Health PEI shall ensure that related health records of the patient are retained until the matter has been finally resolved. (EC49/11)

Destruction of records

19. Health PEI shall ensure that policies and procedures consistent with the Act and these regulations are established for the destruction of health records. (EC49/11)

Disclosure of health records

20. (1) An administrator shall not permit any person to remove, review, receive information from, or reproduce and retain a copy of a health record, except in accordance with this section or as otherwise required or permitted by law.

(2) An administrator shall permit a person with a court order issued by a court of competent jurisdiction to remove, review, receive information from, or reproduce and retain a copy of a health record in accordance with the court order.

Court order

(3) The following persons may review, receive information from, or reproduce and retain a copy of a health record:

Review, receive information from, reproduce and retain a copy

(a) the patient to whom the health record pertains;

(b) the parent or guardian of a patient to whom the health record pertains who is not capable of making health care decisions for himself or herself;

(c) the personal representative of a deceased patient to whom the record pertains, for a purpose related to the administration of the patient's estate;

(d) a person who has the written consent of a person referred to in clauses (a) to (c);

(e) an officer or employee of Health PEI or the Department of Health and Wellness for the purpose of quality improvement, risk assessment or the assessment of employee performance or conduct;

(f) a representative of government's Self-Insurance and Risk Management Fund;

(g) a coroner, police officer or a person authorized by a coroner for the purposes of an investigation or an inquest conducted pursuant to the *Coroners Act* R.S.P.E.I. 1988, Cap. C-25;

(h) a person with a written direction from the Deputy Minister of Veterans Affairs (Canada) or a person designated by him, where the patient is a member or former member of Her Majesty's military, naval or air force of Canada or the RCMP;

(i) a professional regulatory body for the purpose of carrying out its duties pursuant to an enactment with respect to regulating a health profession.

(4) The following persons may review or receive information from a health record:

Review or receive information from

(a) an accreditation surveyor;

(b) a member of the medical staff or another health care professional for,

(i) teaching purposes,

(ii) scientific research that has been approved by the Board or a person or committee designated by the Board, or

(iii) a quality improvement activity;

(c) a member of a deceased patient's immediate family or a person with whom the deceased patient had a close personal relationship, in accordance with the policies and procedures of Health PEI, where the information relates to the circumstances surrounding the death of

the patient or the treatment recently received by the patient at a hospital.

Health care professional

(5) Any health care professional who is providing care to a patient may review, receive information from and add information to the patient's medical record as required for the purpose of providing care to the patient. (EC49/11)

Accreditation Canada – access to operational records

21. (1) Health PEI shall permit a surveyor authorized by Accreditation Canada to examine and audit all books, accounts and records pertaining to the operation of a hospital.

Accreditation Canada – access to health records

(2) An administrator of a hospital shall permit a surveyor authorized by Accreditation Canada to inspect or receive information from any health record relating to patients of the hospital, at any time, for the purpose of carrying out an accreditation survey. (EC49/11)