PRINCE EDWARD ISLAND
ÎLE-DU-PRINCE-ÉDOUARD

HOSPITALS ACT
HOSPITAL MANAGEMENT REGULATIONS

PLEASE NOTE

This document, prepared by the ***Legislative Counsel Office***, is an office consolidation of this regulation, current to February 25, 2023. It is intended for information and reference purposes only.

This document is ***not*** the official version of these regulations. The regulations and the amendments printed in the ***Royal Gazette*** should be consulted on the Prince Edward Island Government web site to determine the authoritative text of these regulations.

For more information concerning the history of these regulations, please see the ***Table of Regulations*** on the Prince Edward Island Government web site (www.princeedwardisland.ca)

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

Legislative Counsel Office
Tel: (902) 368-4292
Email: legislation@gov.pe.ca

HOSPITALS ACT
Chapter H-10.1

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. Definitions

(1) In these regulations

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

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

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

(d) revoked by EC85/23;

(e) revoked by EC85/23;

(f) revoked by EC85/23;

(g) "**authorized practitioner**" means

(i) a member of the medical staff with privileges at a hospital, or

(ii) a nurse practitioner or midwife authorized by Health PEI to admit, treat and discharge patients at a hospital;

(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;

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

(j) "**communicable disease**" means a communicable disease as defined in the *Public Health Act* R.S.P.E.I. 1988, Cap. P-30.1;

(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;

(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;

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

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

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

(p) revoked by EC85/23;

(q) "**medical practitioner**" means a medical practitioner as defined in the *Regulated Health Professions Act* Medical Practitioner Regulations (EC843/21);

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

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

(s.1) "**midwife**" means a midwife as defined in the *Regulated Health Professions Act* Midwives Regulations (EC709/22);

(s.2) "**most responsible practitioner**" means the authorized practitioner who has principal responsibility for the medical or dental care of a patient at a hospital;

(t) "**nurse practitioner**" means a nurse practitioner as defined in the *Regulated Health Professions Act* Registered Nurses Regulations (EC350/18);

(u) revoked by EC85/23;

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

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

(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;

(z) revoked by EC85/23;

(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.

No authorization granted to exceed privileges or Act governing profession

(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.

No authorization granted to exceed Health PEI authorization or Act governing profession

(3) Nothing in these regulations authorizes a nurse practitioner or midwife to do anything at a hospital that the nurse practitioner or midwife, as the case may be, is not authorized to do under the applicable Act and regulations governing the profession or by Health PEI. *(EC49/11; 85/23)*

MANAGEMENT

2. Operation of hospitals

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

Administrator

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

Duties of 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.

Continuation as 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)*

ADMISSION

3. Admission to hospital

(1) No person shall be admitted to a hospital except on the order of an authorized practitioner who is of the opinion that it is clinically necessary to admit the person.

Deemed admission on birth

(2) A baby born in a hospital is deemed to have been admitted to the hospital in compliance with subsection (1) at the time of birth. *(EC49/11; 85/23)*

4. Register

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

(a) name, gender and age;
(b) health number;
(c) date of admission;
(d) most responsible practitioner;
(e) diagnosis on admission;
(f) date of discharge or death. *(EC49/11; 85/23)*

5. Emergency contact

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

6. Medical care on admission

(1) Within twenty-four hours after the admission of an in-patient for medical treatment, including oral and maxillofacial surgery, the most responsible 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.

Dental care on admission

(2) Within twenty-four hours after the admission of an in-patient for dental treatment, including oral and maxillofacial surgery, the most responsible practitioner shall

(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.

Admission for dental surgery

(3) Revoked by EC85/23. *(EC49/11; 85/23)*

7. Ordering treatment

(1) No person shall order treatment for a patient at a hospital except the patient's most responsible practitioner.

Transfer of responsibility

(2) Where the most responsible practitioner of a patient is unable for any reason to perform his or her professional duties with respect to the patient, the most responsible practitioner shall transfer principal responsibility for the care of the patient to another authorized practitioner with appropriate skills and authority.

Effective transfer

(3) A transfer referred to in subsection (2) is not effective until the authorized practitioner to whom principal responsibility for the care of the patient is being transferred accepts that responsibility. *(EC49/11; 85/23)*

INFECTION CONTROL

8. Isolation wards

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

Isolation if communicable disease

(2) The most responsible practitioner of a patient shall cause the patient to be isolated from other patients if the most responsible practitioner knows the patient is or suspects that the patient may be infected with a communicable disease. *(EC49/11; 85/23)*

ANAESTHESIA

9. Information required before anaesthesia

(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:

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

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

(c) the findings of the most responsible 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.

Post-anaesthetic care

(6) Every anaesthetist who administers an anaesthetic to a patient is responsible for directing the post-anaesthetic care of the patient. *(EC49/11; 85/23)*

SURGICAL OPERATIONS

10. Examination prior to surgery

(1) No surgeon shall perform a surgical operation on a patient unless the surgeon first

(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.

Surgical report

(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.

Post-operative care

(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 authorized practitioner. *(EC49/11; 85/23)*

11. Disposal of tissue

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

Tissue sent to pathologist

(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.

Exception

(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.

Pathology examination and report

(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.

Distribution of pathology 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

(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 or nurse practitioner of the patient. *(EC49/11; 85/23)*

DISCHARGE

12. Discharge from hospital

(1) No person shall order the discharge of an in-patient from a hospital except the most responsible practitioner.

Mandatory discharge

(2) Subject to subsection (3), the most responsible practitioner shall make an order to discharge an in-patient, where

(a) the most responsible practitioner is of the opinion that

(i) it is no longer clinically necessary for the 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) the in-patient has discharged oneself from the hospital; or

(c) the in-patient has died in hospital.

Delay of discharge

(3) The most responsible practitioner may delay making an order to discharge an in-patient until

(a) accommodation becomes available for the in-patient in another hospital or a residential care facility; or

(b) home care services or other community-based support services are available to the in-patient.

Administrator oversight

(4) The administrator shall ensure that an in-patient is discharged and leaves the hospital within 24 hours after an order for the discharge of the in-patient is made. *(EC49/11; 85/23)*

13. Discharge summary

(1) The person who was the most responsible 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.

Records to be completed

(2) An authorized practitioner 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.

Suspension

(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 subsection (1) or (2) until the member of the medical staff so complies. *(EC49/11; 85/23)*

14. *Post mortem* report

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

15. Orders to be written and signed

(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

16. Health records

(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 most responsible 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 authorized practitioners 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 most responsible 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 authorized practitioners 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; 85/23)*

17. Safe and secure storage

Sections 17 to 20 revoked by EC85/23. *(EC49/11; 429/16; 85/23)*

21. Accreditation Canada – access to operational records

(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) Revoked by EC85/23. *(EC49/11; 85/23)*