Interprofessional Clinical Policy & Procedure Manual

Policy & Procedure: Alternative Providers/External Care Providers (Non-Hospital Practitioner)	
Developed By: VP Clinical Services/CNE	Number: 2-5-680
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Policy Statement

In this Policy the term "Alternative Providers/External Care Providers (Non-Hospital Practitioner) means individuals (both regulated and non-regulated) who provide care and/or services at Groves Memorial Community Hospital and/or North Wellington Health Care to the Hospital's inpatients, including but not limited to providers of complementary and alternative medicine, who are not Hospital Staff.

In this Policy the term "Hospital Staff" means all individuals employed by, contracted by, or holding privileges at the Hospital.

In this Policy the term "Physician" means a member of the Hospital Staff who is the Patient's Most Responsible Physician/Practitioner.

This Policy is based on the following principles and the need to appropriately balance these principles:

1. **The Hospital's, the Hospital Staff's and the Physician's duty to act in patient's best interest in accordance with fiduciary and ethical responsibilities and**
2. **Respect for the autonomy, health care goals, and treatment decisions of the Hospital's patients.**

A Patient/substitute decision maker ("SDM") may request that he/she be permitted to engage an Alternative Provider to provide Services as an adjunct to the care being provided by Hospital Staff while they are in-patients at the Hospital.

The Patient/SDM must acknowledge that the Hospital has no legal responsibility regarding the Services provided to the Patient by the Alternative Provider. The Patient/SDM must also acknowledge that the Hospital and/or the Physician may refuse to permit the Alternative Provider to provide Services to the Patient or require the provision of the Services to the Patient to be restricted or terminated at any time at the sole discretion of the Physician and/or Hospital.

Limits/Special Considerations:

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The Hospital and/or the Physician reserves the right, in their sole discretion, to refuse to permit the Alternative Provider to provide Services to the Patient, or require the provision of the Services to the Patient to be restricted (including restricting the access of the Alternative Provider to the Patient, or the Hospital) or terminated at any time if it is deemed to be in the best interest of the Patient and/or the Hospital and/or its patients to do so.

Alternative providers will have no access to the Patient's Health Record. If they have documentation for the Patient health record they will provide it to the Patients nurse to include in the health record.
The Alternative Provider will check with the Patients nurse every visit prior to providing services to the patient to provide for clinical collaboration (not supervision) and coordination of care.
The Alternative Provider will not be permitted to use Hospital equipment.
The Alternative Provider must comply with Hospital Policies and Procedures and not interrupt the care of the patient at any time.
Regulated Alternative Provider must act within their scope of practice at all times and unregulated Alternative Providers must act within their range of competencies at all times.
The Alternative Provider must wear appropriate identification provided by the Hospital.
The Alternative Provider must follow all Confidentiality Policies of the Hospital.

Responsibility:
Patient/SDM
Physicians
Hospital Staff

Procedure:

1. The Patient/SDM assumes the hiring, screening and/or credentialing responsibilities. The Patient/SDM collects and verifies the information and provides the Hospital with a copy of the required documentation.
2. Patient/SDM requests alternative provider and communicates this information to the Most Responsible Nurse.
3. The Most Responsible Nurse provides the package of required documents to the Patient/SDM.
4. Prior to an Alternative Provider being permitted to provide Services to the Patient, the Patient/SDM must complete, gather, review with the Alternative Provider and submit the following required documents to the Most Responsible Nurse.:
   - the "Alternative Provider Consent and Release of Liability" Form (Appendix A)
   - the Alternative Provider is required to contact the Occupational Health & Safety Coordinator. The Occupational Health & Safety Coordinator will notify via email their approval status (once requirements have been met) to the Patient Care Manager and Risk Management.

- Proof of Alternate Providers good standing with college (regulated) or appropriate original credentials of association (unregulated) (eg. Ontario College of Reflexology)
-Unregulated Alternative Providers may also be requested to provide proof of external supervision by a regulated health professional if necessary.
-proof of Alternative Providers current and valid Professional Liability Insurance with coverage of at least $5,000,000 (million), any one occurrence if there will be physical contact with the patient and $2,000,000 (million), any one occurrence, if no physical contact will occur. A "Proof of Insurance" certificate prepared by the insurance carrier is the required form.
-proof of personal injury insurance or WSIB coverage
-police background check or vulnerable persons check if appropriate
- Hospital Confidentiality Agreement signed by the Alternative Provider

5. The Patient Care Manager or designate will review the documentation for completeness against policy requirements and place a copy in the Patient Health Record before any service can proceed.
6. Two copies of the documents are to be completed: one copy for the patient's Health Record and one copy to the patient/SDM,

Appendices:
Consent & Release of Liability Form

References:
The Ottawa Hospital
Guelph General Hospital
HIROC Risk Notes: External Care Providers

Policy & Procedure: Alternative Providers (Non-Hospital Practitioner)

Appendix 1

ALTERNATIVE PROVIDER CONSENT AND RELEASE OF LIABILITY (for Patient/SDM)

Date_____

I,_____ hereby consent to:
(Printed Patient's Name and/or SDM)
(

(Specify type of Services)

To be performed by: _____
(Printed Alternate Provider's Name)

At: _____
(name of Hospital)

I acknowledge that I have voluntarily chosen to engage the above-named Alternative Provider to provide me with the Services specified above during my admission to the Hospital.

I understand that the Alternative Provider is not affiliated with the Hospital and that the Hospital has no legal responsibility whatsoever in relation to the Services provided to me by the Alternative Provider even though the Services are to be provided to me on the Hospital property while I am an in-patient at the Hospital.

I understand and acknowledge that being afforded the opportunity to engage an Alternative Provider to provide the Services to me at the Hospital is a privilege and not a right. The Hospital and/or the Physician reserves the right, in their sole discretion, to refuse or stop the Services, or restrict the access of the Alternative Provider to me or the Hospital, at any time, if it is deemed to be in the best interest of me and/or the Hospital and/or its patients to do so.

I understand it is the Alternative Provider's responsibility (and not the Hospital's or the Physician's) to engage in an informed consent discussion with me regarding the Services, including explaining to me the potential risks and benefits of the Services that the Alternative Provider will provide.

I understand it is the Alternative Provider's (if regulated) responsibility to act within their professional scope of practice. I understand it is the Alternative Provider's (if non-regulated) to act within their range and competencies.

I understand it is ultimately and solely by decision whether to engage the Alternative Provider and to choose the nature of the Services that I will consent to undertake. While I may discuss these decisions with Hospital Staff who are members of my care team, I understand that such discussions

are not to be relied upon by me in making these decisions and any information or advice they provide should be verified and discussed with the Alternative Provider prior to consenting to engage the Alternative Provider and the Services to be provided. I also understand that Hospital Staff engaging in such discussions does not mean that the Alternative Provider or the Services they provide are being endorsed, recommended or ordered by Hospital Staff.

I acknowledge that I have reviewed the Alternative Provider Hospital Policy & Procedure and Alternative Provider Consent and Release of Liability with the above-named Alternative Provider.

I understand that the decision to engage the Alternative Provider is a private agreement between myself and the above named Alternative Provider and therefore that the Hospital, its successors, directors, officers, employees and medical staff and other privileged professionals (collectively, the "Releasee") have no liabilities or obligations arising out of this agreement. I hereby release and forever discharge the Releasee from any and all actions, causes of action, suits, claims and demands whatsoever against the Releasee I or my heirs, executors, administrators or assignees, or any of them, may hereafter have for or by reason of any cause, matter or thing whatsoever with respect to the Services provided by the above-named Alternative Provider or their delegate.

As my relationship with the Alternative Provider is a private agreement between me and the Alternative Provider, I understand I have complete responsibility for full payment of the fees of the Alternative Provider.

I sign this Release on behalf of myself and all other persons entitles under the provisions of the ***Family Law Act*** or similar legislations arising out of said matters.

I acknowledge that I have read this Consent and Release carefully and have signed it of my own free will and without any form of duress being exerted upon me by the Releasee or anyone acting on their behalf.

Dated this _____day of_____, 20_____

_____

Patient or Substitute Decision Maker Signature

_____

Relationship to Patient

_____

Witness (print name and signature)