Health Sciences North
Horizon Santé-Nord

INTER-PROFESSIONAL PRACTICE

STANDARDS

CATEGORY: System-Level Clinical **REVISION DATE:** May 2018
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SUBJECT: **COMPLEMENTARY AND ALTERNATIVE THERAPY BY EXTERNAL PROVIDERS**

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PURPOSE

To ensure patient access to care that is over-and-above that which is offered by HSN.

STANDARDS

Background/Scope	• Complementary and Alternative Therapy is a treatment, technique or approach that has not yet been integrated into the conventional health care model and may not be supported by evidence-based standards. The complementary and alternative therapy is given as an adjunct to conventional treatments or therapy; it is not a substitute for conventional therapy. The most responsible provider (MRP) and health care team must be aware of the treatment/care provided. • **This standard does not apply to cosmetic services such as hairdressing or nail care. Cosmetic services will be permitted at the discretion of the unit manager/delegate.** • HSN is accountable and responsible for all care provided to inpatients. External providers may only access HSN inpatients for assessment and/or clinical intervention as authorized by HSN. • HSN will not assume the responsibility of hiring, screening and/or credentialing or paying the external provider. This rests with the patient or substitute decision maker (SDM). • A complementary or alternative therapy provided in accordance with this document is independent of HSN services and is considered a private contract between the patient/SDM and the external provider. • This standard applies to services that are not available at HSN. This standard does not apply to a family member who provides

	unpaid care (toileting, bathing, ambulation, etc.). Special requests outside the scope of this standard will be escalated to the program director for discussion/decision. • HSN will not be liable for any care provided by the external provider. • Payment for the external provider is the responsibility of the patient, family and/or SDM and will not be arranged by or through the hospital. • Patients/SDMs are responsible to verify private practitioners' proof of registration with their respective colleges and proof of errors, omissions, or professional/commercial malpractice insurance. • **HSN retains the right to stop any external care provision if it is felt to be putting the safety of the patient and/or staff at risk.** • Before initiating complementary and alternative therapy, the patient/SDM is required to obtain authorization from their MRP. • HSN is not obligated to authorize any individual as an external provider.
Authorization of Complementary and Alternative Therapy by an External Provider	• Authorization of complementary and alternative therapy by an external provider may be provided by the MRP, where the MRP is of the opinion that the therapy: o Will not expose the patient, other patients, visitors, staff or the facility to undue risk of harm; o Respects the dignity of the person and the values of the organization; o Will not interfere with or interrupt the patient's plan of care (as provided by the HSN clinical team) or his/her current medications, procedures and treatment; o Does not prolong the patient's length of stay; and o Is not intended to be a substitute for conventional treatment. • The MRP is not responsible for obtaining informed consent for the proposed complementary and alternative therapy. However, before authorizing the provision of the therapy, the MRP/clinical team must have a discussion with the patient/SDM that includes: o Patient's views regarding the therapy; o Patient's health status; o Potential effects (if any) that the MRP knows or believes the therapy could have on the patient, other patients, visitors or staff; o Expected outcome(s) of the therapy; o How the therapy may be incorporated into the patient's plan of care; and o Where applicable, limits to the MRP's knowledge of the requested therapy. • The MRP has no obligation to authorize complementary and alternative therapy, and must not provide authorization if these requirements are not met or if he/she believes that the therapy is inconsistent with the conditions for authorization, does not meet professional guidelines or regulatory expectations, or is otherwise harmful or inappropriate. • The MRP (or delegate) must document the discussion in the patient record, including their decision to authorize (or not authorize) the

	requested therapy. If authorization is refused, the concerns and rationale must also be noted.
Process	• The unit manager (or delegate) will provide the patient/SDM with the *External Provider Agreement for Complementary and Alternative Therapy* and *Patient Agreement and Waiver for Complementary and Alternative Therapy by an External Provider*. • Signed agreements will be placed on the patient's chart prior to provision of treatment by the external provider. • The external provider must provide the patient's care team with a document outlining his/her respective treatment plan. This will be documented on the patient's record. • External providers must identify themselves to HSN staff and obtain an update on the patient's condition prior to commencing each treatment session.
Required Documentation	• The following documentation must be provided to the unit manager (or delegate) prior to the complementary and alternative therapy being provided to the patient: o Signed *Patient Agreement and Waiver for Complementary and Alternative Therapy by an External Provider* **(Appendix A)**. o *External Provider Agreement for Complementary and Alternative Therapy* **(Appendix B)** • The patient/family/SDM is responsible for collecting, verifying the information, and providing a copy of the required documentation to HSN. HSN will not collect the documents from the external provider directly. • All required documentation is reviewed for completeness and a copy is placed in the patient's chart before any service can proceed. • The patient/SDM is responsible to verify the external provider's proof of registration with his/her respective college (if applicable), and proof of liability insurance ($2 million minimum) relevant and specific to the therapy being provided.
Provision of Complementary and Alternative Therapy	• At all times, the external provider must: o Work within the standards and guidelines established by their respective regulatory college/oversight body (if regulated). Unregulated external providers are expected to act within their range of competencies, and not as a medical/care advisor to the patient/SDM. o Inform the MRP of any proposed modifications to the plan of treatment with respect to the complementary and alternative therapy. o Notify the MRP if there is any adverse change to the patient's condition that may be attributed to the therapy. o Document the care provided and provide a copy to the patient's care team to place on the patient's chart. • The external provider is responsible for supplying any equipment associated with the provision of the therapy and for ensuring that the equipment is maintained in proper working order, appropriate for the patient/therapy and used in accordance with accepted standards. • Patient care must never be compromised by any private interests of an external provider.

Restrictions of the External Provider	External providers: • Are not permitted to provide medically necessary care that can be provided by hospital staff. • Are not permitted in the Post Anesthetic Care Unit, Critical Care areas or step-down units. • Must consult with members of the HSN patient care team before unhooking any equipment from patients (i.e. G-tube, oxygen). This must be done in the presence of a qualified HSN practitioner (i.e. nurse, physiotherapist, physician, respiratory therapist). • Are not permitted to perform any controlled acts (i.e. performing a prescribed procedure below the dermis or mucous membrane, dispensing a drug, suctioning, administering a substance by inhalation or injection, joint manipulation, etc.) • Do not have access to the patient's chart. Access to view the patient's chart may be provided only with signed consent from the patient/SDM. • Are not permitted to work with the patient if they are experiencing a fever or signs and symptoms of influenza-like illness, or work in another facility that is experiencing an outbreak.
Access to Patient Personal Health Information and HSN Record	• External providers will not have direct access to the patient's health record at HSN. HSN staff will only share patient information or supply copies of clinical records with consent from the patient/SDM or as required by law. • Discussions regarding clinical outcomes, objectives and concurrent treatment will be treated as confidential, and the sharing of clinical information will be subject to patient/SDM consent.
Termination of Complementary and Alternative Therapy by an External Provider	• The final decision to incorporate or continue a complementary and alternative therapy into a patient's overall plan of care will rest with the MRP. • In keeping with its responsibility for patient care, HSN has the right and complete discretion to restrict or withdraw authorization for an external provider and/or the provision of complementary and alternative therapy at any time. This includes, but is not limited to, situations where: o The patient's well-being and care, plan of care, or the coordination of care is at risk or is being compromised; o Required standards are not met; o The external provider is not complying with applicable HSN policies, procedures and/or expectations or their obligations under the *External Provider Agreement for Complementary and Alternative Therapy.* • The patient/SDM will be advised of any decision to restrict or withdraw authorization, including the reason(s) for the decision, which must also be documented in the patient's record. • If authorization for the external provider or the complementary and alternative therapy is withdrawn, the external provider will immediately cease providing care to the patient.

EDUCATION AND TRAINING

Definitions

1. Complementary and Alternative Therapy: Any treatment or service provided by an external provider that is (i) authorized by a patient's most responsible provider, (ii) generally not available through HSN, and (iii) is an adjunct to the care provided by HSN. For the purposes of this document, complementary and alternative therapy also includes services that are not insured as medically necessary hospital services under the *Health Insurance Act* (Ontario).
2. External Provider: Any regulated or non-regulated individuals or organizations/agencies that provide direct patient care for patients of HSN. An external provider does not include HSN staff/contractors.
3. Most Responsible Provider: The physician, midwife, dentist or registered nurse in the extended class who is most responsible for the HSN inpatient.
4. Substitute Decision Maker: A person, other than the patient, who is legally authorized to make a decision on behalf of the patient. The authority may be granted by the patient himself/herself, by a legal document such as an advance directive, by legislation (i.e. *Mental Health Act*) or by the courts (i.e. court-appointed guardians).

References and Related Documents

External Health Care Providers (HCP) Policy, Scarborough and Rouge Hospital, 2018

HIROC. Risk Note: Hiring External Care Providers, 2017

Privately Employed Regulated and Non-Regulated External Providers, Southlake Regional Health Centre, July 2014

Privately Employed Regulated and Unregulated Health Care Providers, North York General, Feb 2016

Purchase Private Rehabilitation Service – Concurrent Treatment, Toronto East General Hospital

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APPENDIX A

Patient Agreement and Waiver
for Complementary and Alternative Therapy by an External Provider

This is to certify that I, _____, a patient at Health Sciences North ("HSN")
(name of patient)

OR

I, _____, the substitute decision-maker for _____
(name of patient's substitute decision-maker) *(name of patient)*

have hired _____ (the "External Provider") to provide
(name of external provider)

complementary and/or alternative therapy to me/the Patient while admitted to HSN, as follows:

_____

_____

_____ (the "**Services**").
(Print a description of therapy to be provided)

I recognize and acknowledge that the Services are being provided at my request by the External Provider, who is not: i) an external provider contracted by HSN; ii) an employee or agent of HSN; or iii) a health care professional credentialed by HSN.

In hiring this External Provider, I assume responsibility for any and all risks of the Services relative to my/the Patient's current health condition. I also agree to assume complete responsibility for full payment of any and all fees or charges associated with the Services.

I understand that:

- the provision of the Services by the External Provider is subject to the authorization of HSN, and that I am responsible for ensuring that all of the requirements for authorization are met. I have read HSN's standard for *Complementary and Alternative Therapy by External Providers* and understand the requirements that must be met in order for the Services and the External Provider to be authorized. I understand that it is HSN's decision whether to authorize the External Provider to provide the Services to me/the Patient while on HSN property;

- the Services have not been recommended by HSN or my/the Patient's physician or other Most Responsible Provider at HSN, and that the Most Responsible Provider and the HSN clinical care team may not be knowledgeable or trained in the intervention(s).

- the External Provider is responsible for the selection, maintenance, operation and use of any tools, equipment, devices or substances ("Equipment") that may be used in the provision of the Services. I understand that HSN assumes no responsibility for the Equipment or its selection, maintenance, operation or use.

- there may be unanticipated side effects/symptoms as a result of the Services, and that it is my responsibility to inform the External Provider and the Most Responsible Provider if any side effects or symptoms occur. If such side effects or symptoms occur, I understand that the Most Responsible Provider may require that the Services be restricted or stopped.

- HSN has the right and complete discretion to refuse, restrict or withdraw authorization for the External Provider and/or the Services at any time, for any reason.

I understand and agree that HSN takes no responsibility for any harm, loss or damage to me/the Patient, or anyone else who may have a claim under the *Family Law Act* or otherwise, arising or resulting from or relating in any way to the External Provider, the Services or any Equipment.

I agree to release (not take legal action) and indemnify (reimburse, if someone else takes legal action) HSN and its directors, officers, employees, and agents, including physicians, from all actions, causes of action, suits, claims, liability, damages and demands of any kind, whether direct, indirect, special, exemplary, or consequential, including interest thereon (the "Claims") which may occur as a result of the External Provider providing or not providing services to the Patient within HSN.

I have read this Acknowledgement and Waiver before signing it and have been given the opportunity to ask questions about the content. I understand my rights and what signing this Acknowledgement and Waiver means for me.

If signed by the Substitute Decision Maker: As the authorized Substitute Decision Maker for the Patient, I affirm that I have legal authority under the *Health Care Consent Act* to arrange and consent to the provision of the Services by the External Provider.

PRINT Full Name of Patient

Signature of Patient/Substitute Decision-Maker | Date

Signature of Witness | Date

APPENDIX B

EXTERNAL PROVIDER AGREEMENT
FOR COMPLEMENTARY AND ALTERNATIVE THERAPY

I _____ have read and understand the HSN standard for *Complementary and Alternative Therapy by External Providers*. I acknowledge that I am not an employee of Health Sciences North when working in my capacity as a privately employed regulated or unregulated health care provider and have not been retained by the Hospital to provide services. I also acknowledge that the Hospital is not responsible for my acts or omissions.

I acknowledge and understand that I am not covered by the Hospital's Workplace Safety and Insurance Board (WSIB) policy for any injuries that may occur to me while providing care at the Hospital. Further, I acknowledge and agree that the Hospital is not responsible for any injury that may occur to me while I perform health care duties for which I was hired by the patient and/or substitute decision maker.

I understand that I must have liability insurance not less than $2,000,000.

I understand that if I work in another health care facility that is experiencing an infectious outbreak or I am experiencing a fever or signs and symptoms of influenza-like illness, I will not be allowed to work with the patient.

I understand that in the course of my work as a privately employed regulated or unregulated health care provider, Hospital employees shall disclose to me relevant information from the patient plan of care and other relevant information about the patient's condition. I also understand that I am required to disclose any information about the patient's condition to the appropriate Hospital staff and members of patient's family. I agree to hold all information about the patient's condition in strict confidence and not to disclose this information to anyone other than the appropriate Hospital staff, the patient, and members of the patient's family.

_____

Print Full Name of Privately Employed Regulated/Unregulated Health Care Provider

_____ _____

Signature of Privately Employed Regulated/Unregulated Health Care Provider — Date

_____ _____

Signature of Witness to the Above — Date