**Health PEI Policy and Procedures Manual**

***Formal Submission for Approval***

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| --- | --- | --- | --- |
| **TITLE OF DIRECTIVE** | | | |
| **[Name of Facility i.e. QEH, PCH, etc. or Program]** | | | **MEDICAL DIRECTIVE** |
| **Applies To** |  | |
| **Monitoring:** |  | |
| **Date:** | Effective: |  |
|  | **Next Review:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Approving Authority:** | **Health PEI Board** | ***Approval/Signing Authority delegated to Chief Medical Officer*** | |
|  |  | ***Signature*** | ***Date*** |
| ***Endorsement:*** | **Chief Medical Officer** | ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** | ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |
|  |  | ***Signature*** | ***Date*** |
| ***Endorsement:*** | **Provincial Medical Advisory Committee** | ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** | ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |
|  |  | ***Signature*** | ***Date*** |

|  |  |  |
| --- | --- | --- |
| ***Record of Decision*** | Approving Body: | Health PEI Board |
| Meeting Date: |

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| **This is a CONTROLLED document. Any copies of this document appearing in paper form should always be checked against the electronic version prior to use.** | | | |

1. **MEDICAL DIRECTIVE – Description of Order and/or Delegated Procedure**

(This includes a specific description of the procedure or intervention being ordered).

1. **DEFINITIONS**

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| --- | --- |
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1. **RECIPIENT PATIENTS**

(Identifies in general terms which patients may receive the procedure).

1. **AUTHORIZED IMPLEMENTERS**

(This refers to either a specific individual or group of health care professionals practicing in a specific clinical specialty area or with a specific patient population).

1. **INDICATIONS/CONSIDERATIONS**

(This includes broad patient and/or pre-existing circumstances that must be present before the procedure/intervention can be implemented).

1. **CONTRAINDICTIONS**

(This refers to any specific contraindications for implementing the procedure/interventions).

1. **CONSENT**

(Must be obtained either verbally or in writing from patient whenever directive is to be implemented. Indicate who is to obtain and whether verbal or written).

1. **GUIDELINES FOR IMPLEMENTATION**

(List each step of the procedure, treatment or intervention. Identify what physician involvement is required after implementation of the directive. For medication, include generic drug name, dose/dose range, route and frequency).

1. **DOCUMENTATION/COMMUNICATION**

(This includes any documentation requirements and recording location).

1. **MONITORING**

(Indicate to whom issues with the directive are to be routed. Describe process (including competencies) and outcome (related to patient) monitoring mechanisms, including person(s) responsible).

1. **ADMINISTRATIVE APPROVALS**

(Printed Name and Signature of Regulated Health Profession Authority(ies) approving the acceptance of the medical directive (i.e., Chief Nursing Officer) and Date).

1. **REFERENCES**

**Related Documents**

**References**

**Appendices**

1. **STAKEHOLDER REVIEW**

|  |  |
| --- | --- |
| **Group/Committee** | **Dates of Review** |
| *Health PEI Policy Coordinator* |  |
| *Provincial Drugs and Therapeutics Committee* |  |
| *Acute Care Directors of Nursing Committee* |  |
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1. **REVIEW HISTORY**

(This will include the annual date of Review).

This medical directive will be reviewed annually for the first year and then every two years subsequently.

**Review Dates:**