

# *The Hospital Standards Regulations, 1980*

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Saskatchewan Regulations 331/79 (effective January 1, 1980) as amended by Saskatchewan Regulations 107/85, 27/90, 41/91, [31/95](#), [6/96](#), [40/2000](#), [107/2001](#), [116/2003](#), [21/2004](#), [131/2005](#), [51/2006](#), [86/2007](#), [27/2011](#), [108/2013](#) and [70/2014](#).

## **NOTE:**

**This consolidation is not official. Amendments have been incorporated for convenience of reference and the original statutes and regulations should be consulted for all purposes of interpretation and application of the law. In order to preserve the integrity of the original statutes and regulations, errors that may have appeared are reproduced in this consolidation.**

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- 112 Repealed

## SASKATCHEWAN REGULATION 331/79

under *The Hospital Standards Act*

### REGULATIONS UNDER THE HOSPITAL STANDARDS ACT GOVERNING THE OPERATION, MANAGEMENT AND USE OF HOSPITALS AND VARIOUS MATTERS RELATED THERETO

These regulations may be cited as *The Hospital Standards Regulations, 1980*.

#### Interpretation

1 In these regulations:

- (a) **Repealed.** 8 Aug 2014 SR 70/2014 s3.
- (b) **“attend”** means attend as defined in *The Attending Health Professionals Regulations*;
- (c) **“board”** means the board of directors of:
  - (i) a regional health authority; or
  - (ii) a health care organization that operates a hospital;
- (c.1) **Repealed.** 3 Jne 2011 SR 27/2011 s3.
- (d) **“chiropractic staff”** means those chiropractors who have been appointed as members of the chiropractic staff by a board;
- (e) **“chiropractor”** means a chiropractor who is entitled to practise chiropractic pursuant to *The Chiropractic Act, 1994*;
- (f) **Repealed.** 21 Sep 2007 SR 86/2007 s3.
- (g) **Repealed.** 3 Jne 2011 SR 27/2011 s3.
- (h) **“dental staff”** means those dentists who have been appointed as members of the dental staff by a board;
- (i) **“dentist”** means a dentist who is entitled to practise dentistry pursuant to *The Dental Disciplines Act*;
- (j) **“emergency”** means the condition of a patient whose life or health is in immediate danger, and where, in the recorded opinion of the attending physician, any delay in administering treatment would increase the danger;
- (k) **Repealed.** 21 Sep 2007 SR 86/2007 s3.
- (l) **Repealed.** 21 Sep 2007 SR 86/2007 s3.
- (m) **Repealed.** 23 Dec 2005 SR 131/2005 s3.
- (n) **Repealed.** 23 Dec 2005 SR 131/2005 s3.
- (o) **Repealed.** 23 Dec 2005 SR 131/2005 s3.
- (p) **Repealed.** 8 Aug 2014 SR 70/2014 s3.

- (q) **“hospital”** means a facility designated as a hospital pursuant to *The Facility Designation Regulations*;
- (r) **“inpatient”** means an individual who has been admitted to, and assigned a bed in, a hospital for the purpose of receiving diagnostic, medical, surgical, rehabilitation, mental health or obstetrical services;
- (s) **Repealed.** 23 Dec 2005 SR 131/2005 s3.
- (t) **Repealed.** 23 Dec 2005 SR 131/2005 s3.
- (u) **“JURSI”** or **“Junior Undergraduate Rotating Student Intern”** means a person:
- (i) who is receiving instruction in the final year of study in a school or college of medicine; and
  - (ii) whose name appears on the educational register maintained by the College of Physicians and Surgeons of Saskatchewan;
- (v) **“major operation”** means an operation which, because of its nature or difficulty or the condition of the patient or the length of time required to operate or the lack of adequate facilities and skilled personnel to handle complications, constitutes a hazard to life or a danger of disability to the patient;
- (w) **“major regional anaesthetic”** means subarachnoid, peridural, plexus block or total limb anaesthetics;
- (x) **Repealed.** 3 Jne 2011 SR 27/2011 s3.
- (y) **“medical intern”** means an intern or resident whose name appears on the educational register maintained by the College of Physicians and Surgeons of Saskatchewan as an intern or resident;
- (z) **Repealed.** 21 Sep 2007 SR 86/2007 s3.
- (aa) **“medical staff”** means those physicians who have been appointed as members of the medical staff by a board;
- (aa.01) **“midwife”** means a midwife who is entitled to practise midwifery pursuant to *The Midwifery Act*;
- (aa.02) **“midwifery staff”** means those midwives who have been appointed as members of the midwifery staff by a board;
- (aa.1) **“nurse practitioner”** means a registered nurse who is entitled pursuant to *The Registered Nurses Act, 1988* to practise in the nurse practitioner category;
- (aa.2) **“nurse practitioner staff”** means those nurse practitioners who have been appointed as members of the nurse practitioner staff by a board;
- (bb) **“outpatient”** means an individual who has been registered with a hospital for the purpose of receiving diagnostic, medical, surgical, rehabilitation or mental health services;
- (cc) **Repealed.** 3 Jne 2011 SR 27/2011 s3.

- (cc.1) **“physician”** means a physician who is entitled to practise medicine pursuant to *The Medical Profession Act, 1981*;
- (dd) **Repealed.** 21 Sep 2007 SR 86/2007 s3.
- (ee) **Repealed.** 21 Sep 2007 SR 86/2007 s3.
- (ff) **Repealed.** 21 Sep 2007 SR 86/2007 s3.
- (gg) **Repealed.** 23 Dec 2005 SR 131/2005 s3.
- (hh) **Repealed.** 8 Aug 2014 SR 70/2014 s3.
- (ii) **“registered nurse”** means a person who is:
- (i) registered as a practising member of the Saskatchewan Registered Nurses’ Association pursuant to *The Registered Nurses Act, 1988*; and
- (ii) is in good standing and not under suspension;
- (jj) **Repealed.** 3 Jne 2011 SR 27/2011 s3.
- (kk) **Repealed.** 21 Sep 2007 SR 86/2007 s3.
- (ll) **“separation”** means the discharge or death of an inpatient;
- (mm) **Repealed.** 23 Dec 2005 SR 131/2005 s3.
- (nn) **Repealed.** 23 Dec 2005 SR 131/2005 s3.
- (oo) **Repealed.** 23 Dec 2005 SR 131/2005 s3.
- (pp) **Repealed.** 23 Dec 2005 SR 131/2005 s3.
- (qq) **Repealed.** 23 Dec 2005 SR 131/2005 s3.
- (rr) **“surgeon”** means the member of the medical staff who performs a surgical operation on a patient.

4 May 90 SR 27/90 s3; 8 Mar 96 SR 6/96 s3; 7  
 May 2004 SR 21/2004 s3; 23 Dec 2005 SR 131/  
 2005 s3; 21 Sep 2007 SR 86/2007 s3; 3 Jne 2011  
 SR 27/2011 s3; 8 Aug 2014 SR 70/2014 s3.

- 2 Repealed.** 17 Oct 2003 SR 116/2003 s3.
- 3 Repealed.** 17 Oct 2003 SR 116/2003 s3.
- 4 Repealed.** 30 Jne 2000 SR 40/2000 s3.
- 5 Repealed.** 30 Jne 2000 SR 40/2000 s3.
- 6 Repealed.** 17 Oct 2003 SR 116/2003 s4.
- 7 Repealed.** 17 Oct 2003 SR 116/2003 s4.

#### PROPORTION OF BEDS TO BE STANDARD WARD ACCOMMODATION

- 8 Repealed.** 23 Dec 2005 SR 131/2005 s4.

## OUTPATIENT SERVICES

**9 Repealed.** 7 May 2004 SR 21/2004 s4.

**10 Repealed.** 7 May 2004 SR 21/2004 s4.

## NURSING STAFF

**11 Repealed.** 3 Jne 2011 SR 27/2011 s4.

## HEALTH RECORDS

**Medical history, physical examination and diagnosis**

**12(1)** Subject to subsection (2), within 48 hours of the admission of a patient to a hospital, the board shall require the attending physician, a physician designated by the attending physician, the attending midwife or a midwife designated by the attending midwife to:

- (a) take and record a medical history of the patient;
- (b) make and record a physical examination of the patient; and
- (c) make and record a provisional diagnosis of the patient's condition.

(2) Subsection (1) does not apply:

- (a) where:
  - (i) within 30 days prior to being admitted to the hospital, the medical history, results of the physical examination and provisional diagnosis of the patient mentioned in subsection (1) were recorded by the attending physician, a physician designated by the attending physician, the attending midwife or a midwife designated by the attending midwife for the purpose of admitting the patient to the hospital for the medical condition in relation to which the patient is being admitted; and
  - (ii) on admission of the patient, an interval note is prepared by the attending physician, a physician designated by the attending physician, the attending midwife or a midwife designated by the attending midwife; or
- (b) where the patient is readmitted to the same hospital within 30 days of being discharged from the hospital and:
  - (i) the diagnosis of the patient's condition is the same when the patient is discharged; and
  - (ii) the attending physician, a physician designated by the attending physician, the attending midwife or a midwife designated by the attending midwife prepares an interval note.

(3) The board shall require to be prepared for every inpatient or outpatient, a patient's health record including:

- (a) identification;
- (b) chief complaint;
- (c) history of present illness;
- (d) history of past illnesses where relevant;
- (e) family and social history where relevant;
- (f) prenatal progress report where the patient is an obstetrical case;
- (g) physical examination;
- (h) provisional diagnosis;
- (i) final diagnosis, stated in Standard Nomenclature;
- (j) condition on discharge or transfer;
- (k) summary of services provided;
- (l) original and signed reports of any:
  - (i) consultations;
  - (ii) diagnostic tests, examinations, or findings and interpretations;
  - (iii) medical, surgical, obstetrical and rehabilitation treatments;
  - (iv) pathological findings;
  - (v) operations and anaesthetics;
- (m) graphic charts, progress reports including any notes;
- (n) certification of death, including time and cause of death;
- (o) post-mortem report if an autopsy is done;
- (p) reports of any follow-up information such as death after discharge.

(4) The board shall require:

- (a) the medical staff;
- (b) the dental staff;
- (c) the chiropractic staff;
- (c.1) the nurse practitioner staff;
- (c.2) the midwifery staff;
- (d) the residents;
- (e) the medical interns;
- (f) the JURSI; and
- (g) other members of the hospital staff;

to prepare the records for which they are responsible.

**Health record**

**13(1)** The discharge summary of the patient's health record shall be completed by the attending physician or attending midwife within seven days after the patient's separation.

(2) The patient's health record shall be completed and signed by the attending physician, the physician designated by the attending physician, the attending midwife or the midwife designated by the attending midwife within twenty-one days of the patient's separation.

(3) Each physician or midwife shall sign those parts of the health record for which the physician or midwife is responsible.

(4) The attending physician shall read and if necessary alter entries made by medical intern or JURSI staff and shall then sign the patient's health record to indicate that it has been properly completed.

7 Dec 79 SR 331/79 s13; 21 Sep 2007 SR 86/2007 s5.

**Report, diagnosis and disposal of case**

**14** For each outpatient, a report of the nature and extent of the injury or illness, the diagnostic procedures undertaken, the treatment given, and the diagnosis and disposal of the case, shall be completed and signed within forty-eight hours by the attending physician, chiropractor, dentist, nurse practitioner or midwife and shall become part of the patient's health record.

7 Dec 79 SR 331/79 s14; 4 May 90 SR 27/90 s8; 7 May 2004 SR 21/2004 s5; 21 Sep 2007 SR 86/2007 s6.

**Health record to be retained**

**15(1)** Subject to subsection (2), the patient's health record shall be retained by the hospital for a minimum period of ten years from the date of last discharge or until age nineteen if the patient is a minor, whichever period is the longer or for such further period as may be deemed necessary by the hospital after consultation with the medical staff.

(2) Where microfilming is employed, the health record must be retained in its original form for a minimum period of six complete years, and the microfilm must be retained for the remainder of the retention period mentioned in subsection (1).

7 Dec 79 SR 331/79 s15.

**16 Repealed.** 3 Jne 2011 SR 27/2011 s5.

**Orders**

**17** Each order made by a physician, dentist, nurse practitioner or midwife, including standing orders, or individual sets of orders shall be recorded in ink and signed by the physician, dentist, nurse practitioner or midwife, so ordering and shall become part of the patient's health record.

7 Dec 79 SR 331/79 s17; 7 May 2004 SR 21/2004 s6; 21 Sep 2007 SR 86/2007 s8.

**Transfer**

**18** Every hospital discharging a patient for transfer to another hospital shall complete an interfacility transfer form and send it with the patient.

7 Dec 79 SR 331/79 s18.

## RADIOLOGY

**19 Repealed.** 21 Sep 2007 SR 86/2007 s9.

**20 Repealed.** 21 Sep 2007 SR 86/2007 s9.

**21 Repealed.** 7 May 2004 SR 21/2004 s8.

## LABORATORY PROCEDURES

**Laboratory procedures**

**22(1)** The results of all laboratory procedures shall be recorded and such reports shall become part of the patient's health record.

(2) Special examinations which cannot be made in a hospital laboratory shall be referred to a laboratory capable of carrying out the examination. The reports of such special examinations shall become part of the patient's health record.

7 Dec 79 SR 331/79 s22.

**23 Repealed.** 30 Jne 2000 SR 40/2000 s4.

**24 Repealed.** 17 Oct 2003 SR 116/2003 s5.

**25 Repealed.** 17 Oct 2003 SR 116/2003 s5.

**26 Repealed.** 21 Sep 2007 SR 86/2007 s10.

**27 Repealed.** 21 Sep 2007 SR 86/2007 s10.

## FOOD PREPARATION AND STORAGE FACILITIES

**28 Repealed.** 30 Jne 2000 SR 40/2000 s5.

**29 Repealed.** 23 Dec 2005 SR 131/2005 s5.

**30 to 33 Repealed.** 30 Jne 2000 SR 40/2000 s6.

**Meat products**

**34(1)** In this section:

(a) **“animal”** means any animal in the class of mammals or birds that is slaughtered and processed as a meat product for human consumption;

(b) **“meat product”** means:

(i) a carcass;

(ii) the blood of an animal or a product or by-product of a carcass; or

(iii) a product containing anything mentioned in subclause (ii).

(2) Meat products that are used in food prepared in or for, and served in, hospitals must be:

- (a) obtained from sources that are subject to inspection by:
  - (i) the Government of Saskatchewan or an agency of that government;
  - (ii) the Government of Canada or an agency of that government; or
  - (iii) the government of a province or territory of Canada or an agency of that government; and
- (b) processed in facilities that are subject to inspection by:
  - (i) the Government of Saskatchewan or an agency of that government;
  - (ii) the Government of Canada or an agency of that government;
  - (iii) the government of a province or territory of Canada or an agency of that government; or
  - (iv) a regional health authority.

3 Jan 2014 SR 108/2013 s2.

**35 to 37 Repealed.** 30 Jne 2000 SR 40/2000 s7.

#### MEDICAL STAFF

- 38 Repealed.** 9 Jne 2006 SR 51/2006 s2.
- 39 Repealed.** 9 Jne 2006 SR 51/2006 s2.
- 40 Repealed.** 23 Dec 2005 SR 131/2005 s6.
- 41 Repealed.** 9 Jne 2006 SR 51/2006 s2.
- 42 Repealed.** 9 Jne 2006 SR 51/2006 s2.
- 43 Repealed.** 9 Jne 2006 SR 51/2006 s2.
- 44 Repealed.** 9 Jne 2006 SR 51/2006 s2.
- 45 Repealed.** 17 Oct 2003 SR 116/2003 s6.
- 46 Repealed.** 9 Jne 2006 SR 51/2006 s2.
- 47 Repealed.** 9 Jne 2006 SR 51/2006 s2.
- 48 Repealed.** 9 Jne 2006 SR 51/2006 s2.
- 49 Repealed.** 7 May 2004 SR 21/2004 s9.

## DENTAL STAFF

**50 Repealed.** 9 Jne 2006 SR 51/2006 s2.

## CHIROPRACTIC STAFF

**50.1 Repealed.** 9 Jne 2006 SR 51/2006 s2.

## REQUIRED PROCEDURES FOR PREGNANT WOMEN AND NEWBORN

**51 Repealed.** 21 Sep 2007 SR 86/2007 s11.

**52 Repealed.** 3 Jne 2011 SR 27/2011 s6.

**53 Repealed.** 8 Aug 2014 SR 70/2014 s5.

**54 Repealed.** 3 Jne 2011 SR 27/2011 s7.

## SURGICAL OPERATIONS

**55 Repealed.** 4 Jan 2002 SR 107/2001 s2.

**No surgery before medical history, physical examination and diagnosis**

**55.1** Except in the case of an emergency, no person shall perform a surgical operation on a patient unless the attending physician or nurse practitioner, or a physician or nurse practitioner designated by the attending physician or nurse practitioner has:

- (a) taken and recorded a medical history of the patient;
- (b) made and recorded the results of a physical examination of the patient;  
and
- (c) made and recorded a provisional diagnosis of the patient's condition.

7 Jne 91 SR 41/91 s4.

**Surgery**

**56(1) Repealed.** 30 Jne 2000 SR 40/2000 s9.

(2) Before a patient is submitted to surgery involving the administration of a general or major regional anaesthetic, a complete history, physical examination and a recorded preoperative diagnosis shall be furnished by the surgeon or any physician authorized by him except that where the surgeon is of the opinion that the delay occasioned in obtaining such history and making such examination would be detrimental to the patient, he shall so state in writing, but in such event, the preoperative diagnosis shall be furnished and signed by the surgeon.

(3) Where the surgery is to be performed by a dental surgeon, he shall record the preoperative diagnosis and the attending physician shall complete a history and physical examination.

- (4) Where a surgeon or dentist performs a surgical operation in a hospital, he shall have prepared and signed within forty-eight hours of the operation, a description of the operative procedure, findings, and the postoperative diagnosis, which description shall become part of the patient's health record.
- (5) The description mentioned in subsection (4) may be prepared by a physician who observed the entire operation, but shall be approved and signed by the surgeon or dentist who performed the operation.
- (6) Where the operation has been performed by a dental surgeon, he shall be responsible for the postoperative dental care of the patient.
- (7) Any tissues or sections of tissues removed during a surgical procedure or curettage shall be immediately set aside by the surgeon operating and shall be forwarded with a short history of the case and a statement of his findings for examination by a pathologist. Any tooth, tonsil, prepuce, haemorrhoid, hernial sac, finger, toe, hand, foot, arm or leg removed or amputated, shall not so be forwarded unless the surgeon or the hospital desires a special examination, but a gross description of the tissue shall be noted in the report of the operation.
- (8) The pathology report shall become part of the patient's health record.
- (9) In every surgical procedure, a surgical instrument and sponge count shall be conducted and charted for inclusion with the health record. This count shall be done prior to and at the conclusion of the procedure for the purpose of properly accounting for these items, and the result recorded on the patient's health record.

7 Dec 79 SR 331/79 s56; 30 Jne 2000 SR 40/2000 s9; 21 Sep 2007 SR 86/2007 s13; 3 Jne 2011 SR 27/2011 s8.

**57 Repealed.** 17 Oct 2003 SR 116/2003 s7.

#### ANAESTHESIA

**58 Repealed.** 8 Aug 2014 SR 70/2014 s7.

**59 Repealed.** 3 Jne 2011 SR 27/2011 s9.

#### INFECTIONS AND COMMUNICABLE DISEASE CONTROL

**60 Repealed.** 21 Sep 2007 SR 86/2007 s14.

**61 Repealed.** 21 Sep 2007 SR 86/2007 s14.

**62 Repealed.** 21 Sep 2007 SR 86/2007 s14.

**63 Repealed.** 17 Oct 2003 SR 116/2003 s8.

**64 Repealed.** 21 Sep 2007 SR 86/2007 s15.

## PHYSICAL FACILITIES

- 65 Repealed.** 17 Oct 2003 SR 116/2003 s9.  
**66 Repealed.** 17 Oct 2003 SR 116/2003 s9.  
**67 Repealed.** 30 Jne 2000 SR 40/2000 s10.  
**68 Repealed.** 17 Oct 2003 SR 116/2003 s10.  
**69 to 83 Repealed.** 30 Jne 2000 SR 40/2000 s11.

## MORTUARY

- 84 Repealed.** 21 Sep 2007 SR 86/2007 s16.

## HOSPITAL STAFF

- 85 Repealed.** 3 Jne 2011 SR 27/2011 s10.  
**86 to 97 Repealed.** 30 Jne 2000 SR 40/2000 s13.

## HOSPITAL DISASTER PLAN

- 98 Repealed.** 21 Sep 2007 SR 86/2007 s17.  
**99 to 102 Repealed.** 30 Jne 2000 SR 40/2000 s14.

## INSPECTION

- 103 Repealed.** 23 Dec 2005 SR 131/2005 s9.  
**104 Repealed.** 17 Oct 2003 SR 116/2003 s11.  
**105 Repealed.** 17 Oct 2003 SR 116/2003 s11.

## CLASSIFICATION OF HOSPITALS

- 106 Repealed.** 23 Dec 2005 SR 131/2005 s10.

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