



HOSPITAL & MEDICAL BY-LAWS

MAY 2024

Stanlake Private Hospital Pty. Ltd. ABN: 47 006 896 322 T/as Western Private Hospital
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Review Date:	May 2024	Review Period- 5 years- 2029
Approved By:	Board of Management	
Version	# 4- May 2024	

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1. Governance structure

1.1 Definition of Governing Body

The governing body for the Western Private Hospital is the Board of Directors of Stanlake Private Hospital Pty Ltd trading as Western Private Hospital

1.2 Structure of the Board of Directors

The Board consists of a selection of the financial Directors from Stanlake Private Hospital Pty Ltd.

The Chief Executive Officer acts as secretary to the Board and in an ex-officio capacity on the Board.

1.3 Meetings of the Board of Directors

The Board meets quarterly to review the operations of the Hospital, including its compliance with operational and strategic plans.

1.4 Powers and duties of the Board of Directors

The Board sets all policies necessary for the effective functioning of the Hospital in accordance with the overall strategic direction of the Hospital.

Specific duties of the Board include, but are not limited to:

- developing and overseeing the strategic direction of the Hospital;
- ensuring that the care extended to patients is of the highest quality and that the services provided are appropriate;
- ensuring the compliance by the Hospital with all regulations and statutes of the State and Commonwealth Health Departments, Local Government Authorities or any other regulatory body which has bearing upon those operations;
- reviewing and adopting the By-laws which govern the activities of the Hospital in general and the medical staff in particular;
- establishing a policy for the accreditation of medical practitioners to the Hospital and the appropriate mechanisms to achieve that;
- ensuring that the management identifies the appropriate services to be provided by the Hospital, and that adequate resources are available to provide them;
- ensuring that adequate financial records are maintained for the Hospital and that the appropriate audits of procedures to ensure their accuracy are carried out;
- ensuring the continuity of its governance by delegation between meetings of operational control to the Chief Executive Officer.

1.5 Relations with the Hospital

The Board, being committed to the concept of safety & quality assurance, ensures that the Hospital provides an annual plan for its safety & quality assurance activities and that it receives a report from the Quality & Safety Committee at regular intervals on the progress towards the objectives set out in that plan.

The Board ensures that there is sufficient forward planning carried out in the Hospital so that the Hospital is able to fully address the requirements of its Patients and the needs of providing those services. This takes the form of an overall strategic plan for the Hospital's activities.

1.6 Relations with Medical Practitioners

The Board recognises that harmonious relations with Medical Practitioners are essential for the effective operation of the Hospital. Equally, it sees the need to ensure that the Medical Practitioners who use the Hospital are appropriately qualified for the procedures being carried out.

To give effect to these aims it has delineated the procedures and policies which govern the Accreditation of Medical Practitioners to the Hospital and the conduct of activities.

The Board relies on the recommendation of the Medical Advisory Committee on Accreditation of Medical Practitioners as a self-regulatory mechanism for Medical Practitioners.

2. Administration

2.1 Chief Executive Officer

The Chief Executive Officer shall be given the authority and responsibility to manage the day to day operations of the Hospital. This is subject to such policies as may be adopted and such directives as may be issued by the Board.

- (a) The authority and general duties of the Chief Executive Officer shall include responsibility for:
- (i) Implementation of the policies and strategic direction established by the Board with respect to the day to day operation of the Hospital.
 - (ii) Involvement in the preparation of the annual operating and capital budgets covering the operation of the Hospital and the monitoring of the actual results against those budgets.
 - (iii) Selection, employment, control, and discharge of employees at the Hospital. This includes the development and maintenance of personnel policies and practices of the Hospital as agreed to by the Board.
 - (iv) Co-operation with Medical Practitioners and others providing professional services so as to achieve the optimal quality care for Patients.
 - (v) Ensuring that the Hospital property is maintained in good state of repair and operating condition and that it conforms with the requirements of authorised planning, regulatory and inspecting authorities.
 - (vi) Liaison with the State Department of Health, other health authorities, local government bodies and other authorities on day to day matters affecting the Hospital's operation.
 - (vii) Maintain a system of reporting to the Board to ensure that the Board are kept informed of the performance of the Hospital.
 - (viii) Act as an ex-officio Board member and secretary for the Board, and other such Committees nominated in the By-laws or by the Board.
 - (ix) Maintain a register of all Accredited Practitioners to the Hospital and ensure that all such Accredited Practitioners carry sufficient insurance and appropriate registration.

- (x) Promote the interests of the Hospital and its services within the broader community which the Hospital serves.

2.2 Director of Nursing

The Director of Nursing will be responsible and accountable for the functioning and performance of the nursing activities within the Hospital.

- (a) The authority and general duties of the Director Of Nursing shall include the following:
 - (i) The development of the nursing philosophy and objectives and standards of nursing care for the delivery of safe, efficient, effective and high quality of Patient care.
 - (ii) The initiation, development and implementation of modern methods and concepts of nursing care.
 - (iii) Responsibility for the determination of nursing policy and organisation and ensuring that mechanisms exist to encourage adherence at all times to nursing, Hospital and corporate policies.
 - (iv) To ensure compliance with all legislation and regulations insofar as they affect nursing services.
 - (v) Responsibility for the preparation, management and justification of the nursing budget, ensuring that correct budgetary control is exercised in all nursing areas.
 - (vi) Participation in appropriate Committees as required.
 - (vii) The promotion and maintenance of harmonious interdepartmental and intradepartmental relationships and ensuring good liaison with Medical Practitioners, particularly as it affects the nursing activities of the Hospital and the provision of high quality nursing care.
 - (viii) Responsibility for personnel policies affecting the nursing staff. This includes all recruitment, promotion or termination of personnel to or from approved positions in the nursing service of the Hospital.
 - (ix) To ensure that the staffing of the Hospital is in accordance with Patient needs
 - (x) To ensure the rights of Patients, staff and visitors are observed and that nursing staff are aware of their responsibility in this regard.
 - (xi) Responsibility for the investigation and appropriate action on occurrences, incidents and complaints regarding nursing personnel and/or Patients.
 - (xii) The development of continued education for all nursing personnel and maintenance of in-service training programmes.
 - (xiii) The promotion of a quality assurance programme and ensuring that appropriate action is taken in relation to findings.
 - (xiv) The job descriptions covering the key executive personnel of the Hospital shall be maintained by the Board. These job descriptions will be amended as required from time to time.

3. Lists of Governance Committees

To achieve the above philosophy, a minimum series of committees have been established and are set out below:

CODE:

BOM	Board of Management
MAC	Medical Advisory Committee
EOC	Executive/Operations Committee
CRC	Clinical Review Committee
CC	Credentialing Committee
Q&SC	Quality & Safety Committee
WH&S	Work Health & Safety Committee
FHR&A	Finance Human Resources & Administrative Committee

The composition of these committees, other than the Medical Advisory Committee, will be determined by the Chief Executive Officer after consultation where appropriate with the Medical Advisory Committee, subject to final approval by the Board. Terms of Reference shall be in place for each committee

4. Values of Western Private Hospital

Our Vision

To be a provider of first class healthcare and the hospital of choice for consumers

Our Mission

To provide the resources to deliver best possible outcomes for all patients by promoting excellence in service

Our Values

Accountability
Partnerships
Customer Service
Excellence

4.1 Objectives of the Hospital

To furnish, support and manage facilities, personnel and services to provide medical, surgical, diagnostic and hospital care, both in-patient and out-patient, and other hospital and medically related services to sick, injured or disabled persons without regard to race, creed, colour, sex or national origin.

To provide appropriate facilities and services to best serve the needs of patients, to improve the standards of health care in the community, to encourage education and training of the Hospital and medical staff members and to maintain optimal achievable quality of Patient care.

To carry on such educational activities related to rendering care to sick and injured or to the promotion of health as may be justified by the facilities, personnel, funds or other requirements that are, or can be made available.

To create an annual surplus from operation to pay a reasonable return to the governing body to compensate the Directors for the diversion of financial resources to the Hospital to be self-financing in all but major works.

To adhere to an employment policy that provides equal opportunities to all existing and potential employees.

4.2 Philosophy on the decision making and quality process

The management of the Hospital is strongly committed to the principle of team work in its decision-making process, whilst at the same time reserving the right for the final decision being taken by those who are charged with the responsibility for the relevant decision.

The decision-making process is supported by the Quality & Safety Committee which oversees all safety & quality activities for the Hospital and reports to the Board concerning quality issues and other related matters. The Board support and promote the quality program to ensure continued improvement in process

It is recognised that the best method of decision-making requires involvement of all staff through a formalised structure which allows appropriate staff to express views. This method contributes not only to good decision-making, it also contributes to staff development, motivation, job satisfaction, training and involvement.

The process ensures a good information flow in both directions, resulting in a better-informed staff at all levels. A part of this information flow allows all staff to be involved in:

- (a) review of performance to objectives;
- (b) comparison of financial performance to objectives;
- (c) comparison of performance to monthly parameters,

All of which result in the setting of realistic and achievable objectives, budgets and parameters.

This philosophy also recognises the need to develop good inter-departmental relationships by ensuring that the structure caters for meetings of Departmental Heads and Middle Managers on a regular basis. By meeting and the exchange of minutes of various meetings, individuals become aware of the operations of the whole Hospital. Co-ordination of activities of Departments and Sub-Departments is a major objective of the philosophy.

Using this structure as a basis for policy formulation and decision making brings advantages to both personnel and the Hospital.

The final aspect of the philosophy is to ensure an understanding of the Board's objectives, involvement and requirements at the appropriate levels of personnel.

Definitions and introduction to by-laws

5. Definitions and interpretation

5.1 Definitions

In these By-laws, unless indicated to the contrary:

Accreditation means the process provided in these By-laws by which a person is Accredited.

Accredited means the status conferred on a Medical Practitioner, Dentist or Allied Health Professional to provide services within the Hospital after having satisfied the Credentialing and Scope of Practice requirements provided in these By-laws.

Accredited Practitioner means a Medical Practitioner, Dentist or Allied Health Professional who has been Accredited to provide services within the Hospital, and who may be an **Accredited Medical Practitioner, Accredited Dentist or Accredited Allied Health Professional**

Accredited with Admitting Rights means the entitlement to admit Patients to the Hospital and to provide medical treatment and care to those Patients within the clinical fields approved by the Board in accordance with the provisions of these By-laws.

Adequate Professional Indemnity Insurance means insurance, including run off/tail insurance, to cover all potential liability of the Accredited Practitioner, that is with a reputable insurance company acceptable to the Board and is in an amount and on terms that the Board considers in their absolute discretion to be sufficient. The insurance must be adequate for Scope of Practice and level of activity.

Allied Health Privileges means the entitlement to provide treatment and care to Patients as an Allied Health Professional within the areas approved by the Board in accordance with the provisions of these By-laws.

Allied Health Professional means a person registered under the appropriate legislation to practise as an Allied Health Professional in the State of Victoria, or other categories of appropriately qualified health professionals as approved by the Board.

Behavioural Sentinel Event means an episode of inappropriate or problematic behaviour which indicates concerns about an Accredited Practitioner's level of functioning and suggests potential for adversely affecting Patient safety and welfare or organisational outcomes.

Board means the Board of Management of Western Private Hospital.

By-laws means these By-laws.

Chief Executive Officer means the Chief Executive Officer of the Hospital or any person acting, or delegated to act, in that position.

Clinical Practice means the professional activity undertaken by Accredited Practitioners for the purposes of investigating Patient symptoms and preventing and/or managing illness, together with associated professional activities related to clinical care.

Competence means, in respect of a person who applies for Accreditation, that the person is possessed of the necessary aptitude in the application of knowledge and skills in interpersonal relationships, decision making and Performance necessary for the Scope of Practice for which the person has applied and has the demonstrated ability to provide health services at an expected level of safety and quality.

Credentials means, in respect of a person who applies for Accreditation, the qualifications, professional training, clinical experience and training and experience in leadership, research, education, communication and teamwork that contribute to the person's Competence, Performance and professional suitability to provide safe, high quality health care services. The applicant's history of and current status with respect to professional registration, disciplinary actions, indemnity insurance and criminal regard are relevant to their Credentials.

Credentialing means, in respect of a person who applies for Accreditation, the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of the applicant for the purpose of forming a view about their Credentials, Competence, Performance and professional suitability to provide safe, competent, ethical and high quality health care services within the Hospital.

Credentialing Committee means the Credentialing Committee of the Hospital established by the Board pursuant to these By-laws.

Credentialing Officer Administration officer employed to assist the Chief Executive officer, Director of Nursing and Medical Director in implementing the Credentialing process

Current Fitness is the current fitness required of an applicant for Accreditation to carry out the Scope of Practice sought or currently held. A person is not to be considered as having current fitness if that person suffers from any physical or mental impairment, disability, condition or disorder (including habitual drunkenness or addiction to deleterious drugs) which detrimentally affects or is likely to detrimentally affect the person's physical or mental capacity to practice medicine, dentistry or allied health (as the case may be).

Dentist means, for the purposes of these By-laws, a person registered under the appropriate legislation to practise dentistry in the State of Victoria.

Director of Nursing mean the person appointed to the position of director of nursing, or equivalent position by whatever name, of the Hospital or any person acting, or delegated to act, in that position.

Disruptive Behaviour means aberrant behaviour manifested through personal interaction with Medical Practitioners, hospital personnel, health care professionals, Patients, family members, or others, which interferes with Patient care or could reasonably be expected to interfere with the process of delivering quality care or which is inconsistent with the values of the Hospital.

Emergency Accreditation means the process provided in these By-laws whereby a Medical Practitioner, Dentist or Allied Health Professional is Accredited for a specified short period on short notice in an emergency situation.

External Review means evaluation of the performance of an Accredited Practitioner by an appropriately qualified and experienced professional person(s) external to the Hospital.

Hospital means Stanlake Private Hospital Pty Ltd trading as Western Private Hospital.

Internal Review means evaluation of the performance of an Accredited Practitioner by an appropriately qualified and experienced professional person(s) internal to the Hospital.

Medical Advisory Committee means the Medical Advisory Committee of the Hospital established by the Board pursuant to these By-laws.

Medical Director means the person appointed to the position of Medical Director of the hospital, or any person acting, or delegated to act in this position.

Medical Practitioner means, for the purposes of these By-laws, a person registered under the provisions of the registration legislation to practise medicine in the State of Victoria.

New Clinical Services means clinical services, treatment, procedures, techniques, technology, instruments or other interventions that are being introduced into the organisational setting of the Hospital for the first time, or if currently used are planned to be used in a different way, and that depend for some or all of their provision on the professional input of Medical Practitioners.

Organisational Capability means the Hospital's ability to provide the facilities, services and clinical and non-clinical support necessary for the provision of safe, high quality clinical services, procedures or other interventions. Organisational Capability will be determined by consideration of the availability, limitations and/or restrictions of the services, staffing, facilities, equipment, and support services required.

Organisational Need means the extent to which the Hospital is required to provide a specific clinical service, procedure or other intervention in order to provide a balanced mix of safe, high quality health care services that meet consumer and community needs and aspirations. Organisational Need will be determined by the strategic direction of the Hospital, Clinical Services Plan, business and operational plans of the Hospital.

Patient means a person admitted to, or treated as an outpatient at, the Hospital.

Performance means the extent to which an Accredited Practitioner provides health care services in a manner which is consistent with known good Clinical Practice and results in expected patient benefits.

Re-accreditation means the process provided in these By-laws by which a person who already holds Accreditation may apply for and be considered for Accreditation following the probationary period or any subsequent term.

Scope of Practice means the extent of an individual Accredited Practitioner's Clinical Practice within the Hospital based on the individual's Credentials, Competence, Performance and professional suitability, and the Organisational Capability and Organisational Need of the organisation to support the Accredited Practitioner's scope of clinical practice.

Specialist Medical Practitioner means a Medical Practitioner who has been recognised as a specialist in their nominated category for the purpose of the Health Insurance Act 1973 (Cth) and has received specialist registration in the State of Victoria.

Temporary Accreditation means the process provided in these By-laws whereby a Medical Practitioner, Dentist or Allied Health Professional is accredited for a limited period.

Threshold Credentials means the minimum credentials for each clinical service, procedure or other intervention which applicants for Credentialing, within the Scope of Practice sought, are required to meet before any application will be processed and approved. Threshold credentials, if implemented, will be approved by the Board.

Visiting Allied Health Professional means an Allied Health Professional who is not an employee of the Hospital, and who has been granted Allied Health Accreditation and Scope of Practice pursuant to these By-laws.

Visiting Dentist means a Dentist who is not an employee of the Hospital, and who has been granted Accreditation and Scope of Practice pursuant to these By-laws.

Visiting Medical Practitioner means a Medical Practitioner who is not an employee of the Hospital, who has been granted Accreditation and Scope of Practice pursuant to these By-laws. Visiting medical practitioners include visiting Specialist Medical Practitioners.

5.2 Interpretation

Headings in these By-laws are for convenience only and are not to be used as an aid in interpretation.

In these By-laws, unless the context makes it clear the rule of interpretation is not intended to apply, words importing the masculine gender shall also include feminine gender, words importing the singular shall also include the plural, if a word is defined another part of speech has a corresponding meaning, if an example is given the example does not limit the scope, and reference to legislation (including subordinate legislation or regulation) is to that legislation as amended, re-enacted or replaced.

The Board, Chief Executive Officer, and Director of Nursing may delegate any of the responsibilities conferred upon him/her by the By-laws in his/her complete discretion, but within any delegation parameters approved by the Board.

Any dispute or difference which may arise as to the meaning or interpretation or application of these By-laws or as to the powers of any committee or the validity of proceedings of any meeting shall be determined by the Board. There is no appeal from such a determination by the Board.

5.3 Meetings

Where a reference is made to a meeting, the quorum requirements that will apply are those specified in these By-laws or the terms of reference of the relevant committee.

Committee resolutions and decisions, if not specified in the terms of reference, must be supported by a show of hands or ballot of committee members at the meeting.

Voting, if not specified elsewhere, shall be on a simple majority voting basis and only by those in attendance at the meeting (including attendance by electronic means) entitled to vote. There shall be no proxy vote.

In the case of an equality of votes, the chairperson will have the casting vote.

A committee established pursuant to these By-laws may hold any meeting by electronic means or by telephonic communication whereby participants can be heard.

Resolutions may be adopted by means of a circular resolution.

Information provided to any committee or person shall be regarded as confidential and is not to be disclosed to any third party or beyond the purpose for which the information was made available.

Any member of a committee who has a conflict of interest or material personal interest in a matter to be decided or discussed shall inform the chairperson of the committee and take no part in any relevant discussion or resolution with respect to that particular matter and shall absent themselves from the room during discussions about the matter.

6. Introduction to By-laws

6.1 Purpose of this document

- (a) This document sets out the terms and conditions on which Medical Practitioners, Dentists and Allied Health Professionals may apply to be accredited within the defined Scope of Practice granted, the basis upon which a successful applicant may admit Patients and/or care and treat Patients at the Hospital, and the terms and conditions for continued Accreditation.

Every applicant for Accreditation is required to be given a copy of this document before making an application. It is an expectation of the Hospital that the By-laws are read in their entirety by the applicant as part of the application process.

7. Compliance with By-laws

7.1 By-Laws

- (a) It is a requirement for continued Accreditation that Accredited Practitioners comply with the By-laws at all relevant times when admitting, caring for or treating Patients, or otherwise providing services to the Hospital.
- (b) Any incidence of non-compliance with the By-laws may be grounds for suspension, termination or imposition of conditions.

7.2 Compliance with policies and procedures

Accredited Practitioners must comply with all policies, procedures and codes of conduct of the Hospital.

7.3 Compliance with legislation

Accredited Practitioners must comply with all relevant legislation, including legislation that relates to health and aged care, workplace health & safety, occupational health and safety, antidiscrimination, bullying, harassment, care of children, care of the aged, termination of pregnancy, professional health registration, and any other relevant legislation regulating the Accredited Practitioner and provision of health care in Victoria.

7.4 Insurance and registration

Accredited Practitioners must at all times maintain Adequate Professional Indemnity Insurance and registration with their relevant health professional registration board.

Accredited Practitioners are required to provide annually, prior to their expiration, or at other times upon request, their certificate of Professional Indemnity Insurance and registration with the relevant health professional registration board, and all other relevant licences or registration requirements for the Scope of Practice granted including Radiation Licence and evidence of CPD.

7.5 Standard of conduct

- (a) The Hospital expects a high standard of professional and personal conduct from Accredited Practitioners, who must conduct themselves in accordance with:
 - (i) the code of ethics of the Australian Medical Association or any other relevant code of ethics;
 - (ii) the code of practice of any specialist college or professional body of which the Accredited Practitioner is a member;
 - (iii) the codes of conduct and values of the Hospital; the strategic direction of the Hospital;

- (iv) the limits of their registration or any conditions placed upon Scope of Practice in accordance with these By-laws; and
- (v) all reasonable requests made by the Board or Chief Executive Officer with regard to personal conduct in the Hospital.

Accredited Practitioners must continuously demonstrate Competence and Current Fitness, must not engage in Disruptive Behaviour, and must observe all reasonable requests with respect to conduct and behaviour.

Upon request by the Board or Chief Executive Officer, the Accredited Practitioner is required to meet with all or any of them to discuss matters in a) or b) above, or any other matter arising out of these By-Laws.

7.6 Notifications

Accredited Practitioners must immediately advise the Chief Executive Officer and follow up with written confirmation within 2 days, should:

- (a) an investigation be commenced in relation to the Accredited Practitioner, or about his/her Patient (irrespective of whether this relates to a Patient of the Hospital) by the Accredited Practitioner's registration board, disciplinary body, Coroner, Health Services Commissioner, or another statutory authority;
- (b) an adverse finding be made against the Accredited Practitioner by a civil court, the practitioner's registration board, disciplinary body, Coroner, Health Services Commissioner, or another statutory authority, irrespective of whether this relates to a Patient of the Hospital;
- (c) the Accredited Practitioner's professional registration be revoked or amended, or should conditions be imposed, or should undertakings be agreed, irrespective of whether this relates to a Patient of the Hospital and irrespective of whether this is noted on the public register or is privately agreed with a registration board;
- (d) professional indemnity membership or insurance be made conditional or not be renewed, or should limitations be placed on insurance or professional indemnity coverage;
- (e) the Accredited Practitioner's appointment, clinical privileges or Scope of Practice at any other facility, hospital or day procedure centre alter in any way, including if it is withdrawn, suspended, restricted, or made conditional; or
- (f) the Accredited Practitioner be charged with having committed or is convicted of a sex, violence or other criminal offence. The Accredited Practitioner must provide the Hospital with an authority to conduct at any time a criminal history check with the appropriate authorities.

7.7 Continuous disclosure

- (a) The Accredited Practitioner must keep the Chief Executive Officer continuously informed of every fact and circumstances which has, or will likely have, a material bearing upon:
 - (i) the Credentials of the Health Professional;
 - (ii) the Scope of Clinical Practice of the Health Professional;
 - (iii) the ability of the health Professional to deliver health care services to patients safely within his or her authorised Scope of Clinical Practice; and

- (iv) the Health Professional's professional indemnity insurance status.
- (b) Without limiting the scope of the obligations described by By-law 7.7 (a) an Accredited Health Professional must advise the CEO in writing as soon as possible but at least within fourteen days if any of the following occur:
- (i) he or she ceases to be registered or is suspended from registration under the relevant professional registration laws;
 - (ii) any conditions, limitations or restrictions are imposed by a registration board in relation to his or her practice;
 - (iii) an adverse finding is made against him or her by any registration, disciplinary, investigative or professional body;
 - (iv) his or her appointment to, accreditation at or scope of clinical practice at, any other facility, hospital or day procedure centre is altered in any way other than at the request of the Health Professional;
 - (v) he or she incurs an illness or disability which may adversely affect his or her current fitness
 - (vi) he or she is charged with or convicted of any serious criminal offence or breach of any laws that regulate the provision of health care or health insurance; or
 - (vii) he or she ceases to hold professional indemnity insurance or has his or her professional indemnity insurance made conditional or not renewed.
- (c) Notifiable Conduct and mandatory reporting in relation to review of scope of clinical practice
- (i) The CEO must comply with his or her obligations of mandatory reporting of Notifiable Conduct as prescribed in the *Health Practitioner Regulation National Law Act 2009*
 - (ii) Unless an Accredited Practitioner has the prior written consent of the Board or Chief Executive Officer, an Accredited Practitioner may not use the Hospital's name, the Hospital's letterhead, or in any way suggest that the Accredited Practitioner represents the Hospital.

The Accredited Practitioner must obtain the Board's or Chief Executive Officers prior approval before interaction with the media regarding any matter involving the Hospital or a Patient.

7.8 Disclosure of Interest of Members of Committees

- (a) Determination to effect of matter disclosed
 - (i) The CEO (in consultation with the chairperson of the Committee) will make a determination in relation to a disclosure under this By-Law. Such a determination may include (but is not limited to) making a determination that the member or person will not participate in the Committee meeting when the matter is being considered or that the member or person will not be present while the matter is being considered
- (b) Matters that to not constitute direct or indirect personal interest
 - (i) The fact that a member of any Committee, is a member of a particular clinical discipline will not be regarded as a direct or indirect material personal interest, if that person participates in the Appointment process, the process to consider amendment of the Scope of Clinical Practice, or the suspension or termination of an Accredited Practitioner in the same discipline

7.9 Committees

- (a) The Hospital requires Accredited Practitioners, as reasonably requested by the Board or Chief Executive Officer, to assist it in achieving its mission through membership of committees of the Hospital. This includes committees responsible for developing, implementing and reviewing policies in all clinical areas; participating in medical, nursing and other education programs and attending meetings.
- (b) All information made available to or disclosed in the context of a committee or sub-committee shall be kept confidential unless the information is of a general kind and disclosure outside the committee or sub-committee is authorised specifically by the committee or sub-committee.

7.10 Privacy & Confidentiality

- (a) Accredited Practitioners will manage all matters relating to the confidentiality of information in compliance with the Hospital's policy and the 'National Privacy Principles' established by the *Privacy Act (Cth)* and will not do anything to bring the Hospital or Board in breach of these obligations.
- (b) Accredited Practitioners will comply with the various legislation governing the collection, handling, storage and disclosure of health information.
- (c) Accredited Practitioners will comply with common law duties of confidentiality.
- (d) The following will be kept confidential by Accredited Practitioners:
 - (i) Commercially in confidence business information concerning the Hospital;
 - (ii) The particulars of these By-Laws;
 - (iii) Information concerning the Hospital's insurance arrangements;
 - (iv) information concerning any Patient or staff of the Hospital;
 - (v) information which comes to their knowledge concerning Patients, Clinical Practice, quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services.
- (e) In addition to statutory or common law exceptions to confidentiality, the confidentiality requirements do not apply in the following circumstances:
 - (i) where disclosure is required to provide continuing care to the Patient;
 - (ii) where disclosure is required by law;
 - (iii) where disclosure is made to a regulatory or registration body in connection with the Accredited Practitioner, another Accredited Practitioner, or the Hospital;
 - (iv) where the person benefiting from the confidentiality consents to the disclosure or waives the confidentiality; or
 - (v) where disclosure is required in order to perform some requirement of these By-Laws.
- (f) The confidentiality requirements continue with full force and effect after the Accredited Practitioner ceases to be accredited at the hospital.

7.11 Communication within the Hospital

Accredited Practitioners are required to familiarise themselves with the organisational structure of the Hospital and its various committees.

Accredited Practitioners acknowledge that in order for the organisation to function, effective communication is required, including between the Board, Chief Executive Officer, Director of Nursing, Department Heads and Committees of the Hospital.

Accredited Practitioners acknowledge and consent to communication between these persons and entities of information, including their own personal information, which may otherwise be restricted by the *Privacy Act*. The acknowledgment and consent is given on the proviso that the information will be dealt with in accordance with obligations pursuant to the *Privacy Act* and only for proper purposes and functions.

8. Safety and Quality

8.1 Admission, bookings, availability, communication, & discharge

- (a) All Visiting Accredited Practitioners shall admit or treat Patients at the Hospital on a regular basis and be an active provider of services at the Hospital.
- (b) In order to facilitate clinically safe arrangements for non-emergency elective admissions the following process should be followed:
 - i. A pre admission clinical risk assessment completed by a pre-admission nurse or doctor before admission
 - ii. The results of the pre-admission clinical assessment will be recorded in writing not less than 24 hours before admission
 - The procedure for which the patient is admitted is assessed in relation to the scope of practice of the relevant registered health practitioner providing health services to the patient at the hospital
 - Group and Screen need to be performed in a timely manner in accordance to the Safe Transfusion Practice for Surgery guideline of the blood product provider nominated by the hospital.
 - All admissions should be made through the Booking Officer during office hours from Monday to Friday and through the Grade 5 Hospital Coordinator at other times, with the admission documentation (MR100, 120 & 200) fully completed. Any requirements for high dependency nursing must be notified in advance to the Pre Admission Nurse.
 - Theatre times should be booked through the Perioperative Services Manager or the Hospital Bookings Officer.
 - Reasonable notice should be given for bookings for regular operating lists, which will include the name of the anaesthetist. If preliminary details cannot be provided a week in advance, the Booking Officer should be advised whether all allocated theatre times will be used and the probable number of patients. If this is not done it may be assumed that theatre time and the related beds will not be used, and they will be regarded as available for reallocation on the day in question
 - Cancellations should be notified to the Booking Officer as early as possible so that if substitute bookings are not made, the spare time and beds can be offered to other Accredited Practitioners.

- Additions to operating lists within a week of the scheduled date should not be made without prior consultation with the Theatre Booking Officer about bed availability.
- The order of patients on operating lists should be confirmed to the Booking Officer at least 48 hours before each list.
- Surgeons are asked to give the Bookings Officer as much notice as possible, ordinarily 4 weeks, of any planned absence so that temporary arrangements can be made to utilise theatre time allocated to them. Lists will be faxed to doctors once a month to confirm. It should be noted that regular theatre times are normally allocated to surgeons as individuals and do not necessarily become available to their associates or locums during their absences.
- Every patient for whom a booking is made should be given a copy of the Hospital's patient admission information and instructed to complete and send back to the Hospital before the admission date. If the patient is booked in within a week of their admission the patient should be instructed to fax these forms to the hospital as soon as possible or complete the online form.
- Admission times will be advised by the Hospital and patients shall be advised, at a minimum, the day prior to admission. Discharge time is 10.00am.
- The Board and Chief Executive Officer retain complete discretion to decline a particular request for admission.
- Time out – All accredited practitioners shall participate in the hospital 'Time Out' process prior to the commencement of any invasive procedure.
- Anti-Microbial Stewardship – All accredited practitioners shall participate in the hospitals Antimicrobial Stewardship Program

Responsibility for Patients

- (c) not admit a patient to the Hospital unless a suitable or appropriate bed is available to accommodate that patient;
- (d) admit to the Hospital only those patients who, in the opinion of the CEO, can be properly managed in the Hospital (the CEO may notify Accredited Practitioners from time to time of any categories of patients who are considered inappropriate for admission to the Facility);
- (e) accept full responsibility for his or her patients from admission until discharge, or until the care of the patient is transferred to another Accredited Practitioner;

(f)

Accredited Practitioners must visit all within 24 hours of a patient being newly admitted and patients will be treated by them as frequently as is required by the clinical circumstances and. An Accredited Practitioner will be contactable to review the Patient in person or their on-call or locum cover is available as requested by nursing staff to review the Patient in the Hospital. Accredited Practitioners must ensure that all reasonable requests by Hospital staff are responded to in a timely manner and in particular, Patients are promptly attended to when reasonably requested by Hospital staff for clinical reasons. If Accredited Practitioners are unable to provide this level of care personally, he/she shall secure the agreement of another Accredited Practitioner to provide the care and treatment, and shall advise the staff of the Hospital of this arrangement.

- (g) Accredited Practitioners must be available and attend upon Patients of the Accredited Practitioner in a timely manner when requested by Hospital staff or be available by telephone in a timely manner to assist Hospital staff in relation to the Accredited Practitioner's Patients. Alternatively, the Accredited Practitioner will make arrangements with another Accredited Practitioner to assist or will put in place with prior notice appropriate arrangements in order for another Accredited Practitioner to assist, and shall advise the staff of the Hospital of this arrangement.

It is the responsibility of the Accredited Practitioner to ensure any changes to contact details are notified promptly to the Chief Executive Officer or appropriate member of nursing staff. Accredited Practitioners must ensure that their communication devices are functional and that appropriate alternative arrangements are in place to contact them if their communication devices need to be turned off for any reason.

- (h) A locum must be accredited in accordance with these By-laws and the Accredited Practitioner must ensure that the locum's contact details are made available to the Hospital and all relevant persons are aware of the locum cover and the dates of locum cover.
- (i) Accredited Practitioners must only treat Patients within the Scope of Practice granted.
- (j) Accredited Practitioners are required to work with and as part of a multi-disciplinary health care team, including effective communication – written and verbal, to ensure the best possible care for Patients.

Adequate instructions and clinical handover is required to be given to the Hospital staff and other practitioners (including their on-call and locum cover) to enable them to understand what care the Accredited Practitioner requires to be delivered. The Accredited Practitioner must appropriately supervise the care that is provided by the Hospital staff and other practitioners. Accredited Practitioners acknowledge that the Hospital and nursing staff must comply with legislative, practice, policy and procedural requirements in the provision of care, and will provide instructions that facilitate compliance with this, including in relation to the provision of instructions for medication.

- (k) If care is transferred to another Accredited Practitioner, this must be noted on the Patient medical record and communicated to the Nurse Unit Manager or other responsible nursing staff member.
- (l) Cardiologists must participate in formal on-call arrangements as reasonably required by the Hospital. Persons providing on-call or cover services must be accredited at the Hospital.
- (m) There is no formal physician on-call roster. Afterhours medical registrars will contact practitioners if required regarding currently admitted patients. Accredited Practitioners must advise in writing if they do not wish for their patients to be seen by the hospital registrars.
- (n) The Hospital Surgical Registrar will be allocated to assist for operating lists at the hospitals discretion. For Accredited Practitioners performing surgery to which the Hospital surgical assistant has not been allocated, the protocol for the Operating Theatre Suite must be complied with, arrangements for adequate surgical assistants must be arranged by the Accredited Practitioner at their own expense, they must be ready to operate at the prearranged times
- (o) The theatre pathology register must be completed for every specimen taken and sent to an approved pathology practice
 - (i) The Accredited Practitioner must follow and also allow theatre staff sufficient time to complete their procedural requirements for surgery including 'time out' and item counts.

- (p) Accredited Practitioners must adhere to prearranged session times. If theatre sessions have been requested by the accredited practitioner and allocated then the accredited practitioner must effectively utilise the theatre session. The Nurse Unit Manager has the authority to cancel patients and lists to ensure uninterrupted scheduling. Allowances will be made for emergency procedures.
- (q) For Accredited Practitioners performing anaesthesia, pre-operative assessment must be made and recorded by the accredited practitioner personally, pre-medication orders must be in writing, other than in an emergency, and in an emergency the policy for telephone orders must be complied with. General anaesthesia will not be commenced in the absence of the surgeon and anaesthetic nurse other than in an emergency. The Accredited Practitioner must devote their whole attention to the care of the Patient until they believe that potential complications demanding their immediate attention will no longer occur, acknowledge that nursing staff are not expected or permitted to assume responsibility for the monitoring duties normally performed by an anaesthetist and it is the responsibility of the anaesthetist to arrange appropriate medical supervision if he/she is unavoidably called away while a Patient remains under any form of anaesthesia. The recovery room protocol is adhered to and anaesthetists check on their Patients in the recovery room prior to leaving the Hospital, and if an operation is performed outside the normal theatre and recovery room hours the anaesthetist remains with and supervises the patient during the post-operative period until the patient is conscious and in a stable condition. Anaesthetists are responsible for the patient in the first 24 hours post procedure.
- (r) Anaesthetists are required to notify the hospital if they unable to be available for the 24hr post op care of their patients. If they are unavailable the name of their locum is to be provided to the hospital coordinator or relevant nurse unit manager.

Take into account the policies of the Hospital when exercising judgement regarding the length of stay of patients at the Hospital and the need for ongoing hospitalisation of patients Patients will not be discharged unless approved by the Accredited Practitioner or if unavailable their on-call or locum cover, or if the Patient is insistent then the discharge against medical advice process will be followed. It is the responsibility of the Accredited Practitioner to ensure all information reasonably necessary to ensure continuity of care after discharge is provided to the referring practitioner, general practitioner or other treating practitioner, with a copy of any such documentation included in the Hospital medical record. The accredited practitioner must comply with the discharge policy of the Hospital and ensure all required documentation (including discharge summaries) are completed prior to the patients discharge. Discharge, other than same day patients, should be authorised in time for Patients to vacate their rooms by 1000 hours on the day of discharge.

- (s) be willing, in an emergency or on request by the CEO (or another person authorised by the CEO for this purpose) to assist the staff and other practitioners, where possible and necessary;
- (t) comply with all infection control procedures of the Hospital including appropriate hand hygiene; and
- (u)

8.2 Treatment and financial consent

Accredited Medical Practitioners and Dentists must obtain fully informed consent for treatment (except where it is not practical in cases of emergency) from the Patient or their legal guardian or substituted decision maker in accordance with accepted medical and legal standards and in

accordance with the policy and procedures of the Hospital. For the purposes of this provision, an emergency exists where immediate treatment is necessary in order to save a person's life or to prevent serious injury to a person's health.

The consent will be evidenced in writing and signed by the Medical Practitioner/Dentist and Patient or their legal guardian or substituted decision maker.

It is expected that fully informed consent will be obtained by the Accredited Medical Practitioner/Dentist under whom the Patient is admitted or treated, in accordance with the Medical Practitioner's / Dentist's non delegable duty of care. The consent process will ordinarily include an explanation of the Patient's condition and prognosis, treatment and alternatives, inform the Patient of material risks associated with treatment and alternatives, and then obtain the consent to treatment. The consent process must also satisfy the Hospital's requirements from time to time as set out in its policy and procedures.

Informed consent must also be obtained and documented prior to Blood or Blood Products administration and applying VAC dressings.

Accredited Medical Practitioners and Dentists must provide full financial disclosure and obtain fully informed financial consent; this includes any patient payable gaps for medical treatment and prosthesis from their Patients in accordance with the relevant legislation, health fund agreements, policy and procedures of the Hospital.

It is a condition of admission that the estimated Hospital fees be paid. Any uncertainty about this or any unusual circumstances (such as a self-funded admission) is brought to the attention of the Chief Executive Officer prior to admission.

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8.5 Patient records

Accredited Practitioners must ensure that:

- (a) Patient records held by the Hospital are adequately maintained for Patients treated by the Accredited Practitioner;
- (b) Patient records held by the Hospital are not removed without permission of the Chief Executive Officer;
- (c) Patient records satisfy Hospital policy requirements, legislative requirements, the content and standard required by the Australian Council on Healthcare Standards, accreditation requirements, and health fund obligations. Accredited practitioners in particular acknowledge the importance of complying with legislative and procedural requirements in relation to medication, including the requirements for orders given by telephone;
- (d) they maintain full, accurate, legible and contemporaneous medical records, including in relation to each attendance upon the Patient, with the entries dated, time and signed;
- (e) Patient records include all relevant information and documents, including treatment orders, reasonably necessary to allow Hospital staff and other Accredited Practitioners to care for Patients;
- (f) A procedure report is completed including a detailed account of the findings, technique undertaken, CMBS, complications and post procedure orders;
- (g) An anaesthetic report is completed, as well as documentation evidencing fully informed anaesthetic consent;

- (h) The Accredited Medical Practitioner is encouraged to include the Hospital as a CC in any correspondence sent to the Patients General Practitioner regarding each inpatient admission, for inclusion in the medical record;
- (i) Requests to complete any incomplete Hospital medical records are attended to as soon as reasonably possible;
- (j) Failure to complete medical records and /or discharge summaries may involve temporary suspension of admission rights.

8.6 Financial information and statistics

- (a) Accredited Practitioners must record all data required by the Hospital to meet health fund obligations, collect revenue and allow compilation of health care statistics.
- (b) Accredited Practitioners must complete all certificates required by the patient's health fund as soon as reasonably possible.
- (c) Accredited Practitioners must ensure that all Pharmaceutical Benefits Scheme prescription requirements and financial certificates are completed in accordance with Hospital policy and regulatory requirements.

8.7 Quality improvement, risk management and regulatory agencies

Accredited Practitioners are required to attend and participate in the Hospital's safety, quality, risk management, education and training activities, including clinical audit and peer review activities, and as required by relevant legislation, standards and guidelines. This shall include, but not be limited to

Annual Hand Hygiene competencies
Antimicrobial Stewardship Program
Annual Continuing Professional Development

- (a) All practitioners will practice Open Disclosure principles as set out in the Australian Open Disclosure Framework 2012
- (b) Accredited Practitioners will report to the Hospital incidents and adverse events (including in relation to the Accredited Practitioner's Patients) in accordance with the Hospital policy and procedures and where required by the Chief Executive Officer will assist with incident management, investigation and reviews (including root cause analysis and other systems reviews), and open disclosure processes.
- (c) Accredited Practitioners who sustain a needle stick injury WILL have bloods taken as per Western Private Needlestick and Splash Injury Policy. Failure to comply will be entered into Riskman and notified to Chief Executive Officer.
- (d) Accredited Practitioners will participate in risk management activities and programs, including the implementation by the Hospital of risk management strategies and recommendations from system reviews.
- (e) Accredited Practitioners must provide all reasonable and necessary assistance in circumstances where the Hospital requires assistance from the Accredited Practitioner in order to comply with or respond to a legal request or direction, including for example where that direction is pursuant to a court order, or from the Health Services Commissioner, Coroner, Police, State Health Department and its agencies or departments, Australian Private Hospital Association, and Commonwealth Government and its agencies or departments.

8.8

Clinical Review Committees

The Board and Chief Executive Officer may establish clinical review committees, howsoever which will have the following objectives:

- Assessment and evaluation of quality of health services including the review of clinical practices or clinical competence of persons providing those services
- Reviewing clinical outcomes to identify system or individual practices that impact on patient outcomes: and
- Providing a forum for Accredited Practitioners to meet and discuss relevant clinical and administrative matters

(a) Functions

The clinical review and quality functions of the Clinical Review Committee or Committees, howsoever named, are to:

- (i) review clinical indicators;
- (ii) review mortality and morbidity reports and make recommendations where appropriate;
- (iii) encourage participation in quality projects to improve patient outcomes;
- (iv) review adverse event trends related to clinical practice and where appropriate make recommendations;
- (v) review specific cases identified as an outcome of the reviews
- (vi) notify the CEO of any identified clinical issues and risks at the Hospital.

(b) Meetings of Clinical Review Committee

- (i) The Clinical Review Committee howsoever named, will meet quarterly for formal quality, morbidity and mortality review meetings (**Formal Meetings**) or as otherwise required by the CEO.

8.9

Participation in clinical teaching activities

Accredited Practitioners, if requested, are required to reasonably participate in the Hospital's clinical teaching program.

8.10

New Clinical Services

- (a) Before treating patients with New Clinical Services, Procedures or Interventions, an Accredited Practitioner is required to obtain the prior written approval of the Chief Executive Officer and what is proposed must fall within the Accredited Practitioner's Scope of Practice or an amendment to the Scope of Practice has been obtained.
- (b) The Accredited Practitioner must provide evidence of Adequate Professional Indemnity Insurance to cover the New Clinical Service, and if requested, evidence that private health funds will adequately fund the New Clinical Services.
- (c) If research is involved, then the By-law dealing with research must be complied with.
- (d) The CEO must refer the application to the relevant Committee which will advise on the safety, efficacy and the role of the New Clinical Service, Procedure or other intervention in the context of the Hospital's Organisational need and Organisational capability.

The relevant Committee will advise the CEO:

- (i) whether and under what conditions the new Clinical Service, Procedure or other intervention could be introduced safely to the Hospital: and
 - (ii) whether the new Clinical Service, Procedure or other intervention or equipment is consistent with the Accredited Practitioners Scope of Clinical Practice
- (e) The CEO may seek additional advice about the financial, operational or clinical implications of the introduction of the New Clinical Service Procedure or other intervention.
- (f) The CEO may refuse permission for the introduction of a New Clinical Service, Procedure or other intervention.
- (g) Before approving the introduction of a New Clinical Service, Procedure or other intervention the CEO must be satisfied the New Clinical Service Procedure or other intervention is consistent with the Organisational need and Organisational capabilities of the Hospital
- (h) The Chief Executive Officer's decision is final and there shall be no right of appeal from denial of requests for New Clinical Services.

8.11 Utilisation

Accredited Practitioners will be advised upon Accreditation or Re-Accreditation, or at other times as determined by the Board, of the expectations in relation to exercising Accreditation and utilisation of the facility. Absent special circumstances, the Accredited Practitioner must exercise Accreditation or utilise the facility in accordance with the specified expectations.

Part A– Accreditation of Medical Practitioners

9. Credentialing and Scope of Practice

9.1 Eligibility for Accreditation as Medical Practitioners

Accreditation as a Medical Practitioner will only be granted if the Medical Practitioner demonstrates:

- registration as a Medical Practitioner with the Medical Board of Australia or any accessor body; and
- appropriate medical indemnity insurance in respect of the practitioner's Scope of Clinical Practice
- Preparedness to comply with the By-laws, the Hospital's policies, relevant legislation, standards and guidelines, and provide written declaration of such preparedness.

Medical Practitioners may apply for accreditation using the online CGOV portal or mobile app

10. Medical Advisory Committee

10.1 Medical Advisory Committee

- (a) The Board shall convene a Medical Advisory Committee in accordance with the terms of reference established for the Medical Advisory Committee.
- (b) For matters relating to Accreditation, the Board may establish a sub-committee. This sub-committee will be referred as Credentialing Committee. The Board will approve the members of the sub-committee.

10.2 Establishment, function and powers of the Medical Advisory Committee

- (a) A Medical Advisory Committee shall be established in accordance with the provisions of these By-laws.
- (b) The functions of the Medical Advisory Committee shall be to consider, investigate, report, and make recommendations to the Board with regard to:
 - (i) the betterment of Patient care and the welfare of Patients;
 - (ii) Act in an advisory role to the CEO and Director of Nursing
 - (iii) To act as the Ethics Committee for Western Private Hospital,
 - (iv) the conduct of medical research, investigation and experimentation;
 - (v) the employment by the Hospital of Medical Practitioners;
 - (vi) regulations, by-laws, rules and procedures applying, or to be applied, to Accredited Practitioners;
 - (vii) Establish appropriate sub committees, receive and, where necessary, act upon their reports
 - (viii) Be the formal organisational structure through which the collective views of the accredited practitioner of the hospital shall be formulated and communicated
 - (ix) Provide a forum for communication between the hospital and the hospitals executive and accredited practitioners in relation to patient care and safety throughout the hospital
 - (x) Provide a means whereby Accredited can advise the hospital of the appreciate policies regarding he clinical organisation of the hospital
 - (xi) the dissemination and exchange of information amongst, and the improvement of medical knowledge of, Accredited Practitioners;
 - (xii) such other matters as may be relevant to the proper and efficient functioning of the medical and associated services provided by the Hospital;

10.3 Membership of the Medical Advisory Committee

The Medical Advisory Committee shall include at least five Accredited Practitioners

The Medical Advisory Committee shall be representative of the Accredited Practitioners and aim to consist of:

- (a) one Accredited Practitioner to be elected from each medical group representing a particular specialty or area that has been formed;
- (b) such other elected Accredited Practitioners as is considered necessary and appropriate by the Medical Advisory Committee; and
- (c) the Chief Executive Officer and or the Director of Nursing
- (d) MAC may co-opt the services of any other person (including persons who are not Accredited Practitioners) whether for a specific time or generally, as it sees fit. A person co-opted to assist a MAC has no voting rights.

10.4**Term of Office**

- (a) The Chief Executive Officer and Director of Nursing shall retain office as a Medical Advisory Committee member so long as he/she is appointed as Chief Executive Officer or Director of Nursing and is not subject to the retirement requirements.
- (b) Each Medical Practitioner elected as a member of the Medical Advisory Committee shall hold office for a three year term but may be re-appointed.

10.5**Vacancies**

- (a) Any casual vacancy amongst members may be filled by resolution of the Medical Advisory Committee and any person appointed pursuant to such resolution shall hold office until the time of the next annual meeting.
- (b) The nominee to fill a casual vacancy is subject to approval by the Board.
- (c) If a casual vacancy is from a particular medical group, the replacement will be from the same medical group.
- (d) The continuing members may act notwithstanding any vacancy on the Medical Advisory Committee.

10.6**Meetings of the Medical Advisory Committee**

- (a) The Medical Advisory Committee shall meet not less than four times annually.
- (b) The quorum for a meeting of the Medical Advisory Committee shall be 3 Medical Representative, 1 Hospital Representative.
- (c) The Chief Executive Officer, upon the request of the Chairman or any three Members, convene an additional meeting of the Medical Advisory Committee with at least three days' notice required for such a meeting.
- (d) Each member, other than the Chief Executive Officer and Director of Nursing, shall be entitled to one vote at meetings of the Medical Advisory Committee. In the case of an equally of votes, the Chairman of the meeting shall have the casting vote.
- (e) Where a quorum does not exist, the meeting is to be adjourned and reconvened when a quorum becomes available.

10.7**Chairman**

- (a) At the first meeting of the Medical Advisory Committee held after each annual meeting, the members shall elect one of their number (other than the Chief Executive Officer), as Chairman of the Medical Advisory Committee, and one as the Deputy Chairman, to hold office until the next annual meeting.
- (b) The Chairman, or in their absence, the Deputy Chairman of the Medical Advisory Committee, shall be entitled to take the Chair at all meetings of the Medical Advisory Committee and at the annual meeting. If at any such meeting or annual meeting, the Chairman or in their absence the Deputy Chairman of the Medical Advisory Committee, shall not be present, the members or (as the case may be) the Accredited Practitioners present, shall elect one of their number to be Chairman of the meeting or of the annual meeting, as the case may require.

10.8**Vacation of office**

- (a) A member of the Medical Advisory Committee shall cease to hold office as such:

- (i) if by notice to the Chief Executive Officer they resign from the Medical Advisory Committee; or
 - (ii) upon the Board resolving that they shall cease to hold office as a member.
- (b) A member of the Medical Advisory Committee shall be deemed to have vacated their office:
- (i) if their Accreditation is suspended or terminated;
 - (ii) if they fail to attend, without good cause, more than 2 consecutive meetings.

10.9 Notices

- (a) Any notice required to be given to a member of the Medical Advisory Committee or an Accredited Practitioner, shall be sent by electronic mail to the practitioners preferred online correspondence in the register of Accredited Practitioners, and kept by the Hospital. Such notice shall be deemed to be effective.

10.10 Annual General Meeting

- (a) There shall be an annual general meeting (AGM) of all Accredited Practitioners.
- (b) The purpose of the annual meeting shall be to consider the report from the Chairman of the Medical Advisory Committee, elect members to the Medical Advisory Committee, and discuss matters of relevance to Accredited Practitioners.
- (c) In addition to the annual general meeting (AGM), a special meeting of all Accredited Practitioners may be called with not less than 7 days notice by the Board, Chief Executive Officer, Chairman of the Medical Advisory Committee, or not less than 20% of the Accredited Practitioners. No business shall be conducted at a special meeting other than that set out in the notice for the meeting, unless otherwise permitted by the Chairman of the special meeting. The Board reserves the right to cancel the calling of a special meeting by 20% of the Accredited Practitioners if it is considered vexatious.
- (d) The annual general meeting (AGM) and any special meeting will be chaired by the Chairman of the Medical Advisory Committee, or delegate appointed by the Chairman of the Medical Advisory Committee, with the procedure for the meeting as determined by the Chairman.
- (e) If a resolution from Accredited Practitioners is required outside of an annual or special meeting, then the Board, Chief Executive Officer, or Chairman of the Medical Advisory Committee may circulate the proposed resolution by mail.
- (f) Establishment, function and powers of the Credentialing Committee (Sub Committee of MAC)

10.11 Credentialing Committee

- (a) A Credentialing Committee shall be established in accordance with the provisions of these By-laws.
- (b) The functions of the Credentialing Committee shall be to consider, investigate, report, and make recommendations to the Medical Advisory Committee with regard to:
- (i) input on whether or not any person applying to become an Accredited Practitioner should be granted Accreditation;

- (ii) the terms, conditions and Scope of Practice upon which Accreditation should be granted;
- (iii) whether or not any Accredited Practitioner should have their Accreditation withdrawn
- (iv) regulations, by-laws, rules and procedures applying, or to be applied, to Accredited Practitioners;
- (v) Providing recommendation to the MAC on changes & updates to be made to the Credentialing Policy and By-Laws with supporting Material from NSQHS, Safer Care Victoria and Guidelines received from the Department of Health.
- (vi) Provide a Report to the Medical Advisory committee in regards to recommendations of all Accreditation Applications

10.12 Membership of the Credentialing Committee (Sub Committee of MAC)

- (a) The Credentialing Committee shall include at least **One** Accredited Practitioners
- (b) The Credentialing Committee shall be representative of the Accredited Practitioners and aim to consist of:
 - (i) Medical Director
 - (ii) The Chief Executive Officer
 - (iii) Credentialing Officer
 - (iv) Perioperative Services Manager
 - (v) Pre Admission Manager (optional)
 - (vi) Independent Peer Practitioner

10.13 Term of Office

- (a) Each Member elected as a member of the Credentialing Committee shall hold office for a One year term but may be re-appointed.

10.14 Meetings of the Credentialing Committee (Sub-Committee of MAC)

- (a) The Credentialing Committee shall meet not less than four times annually.
 - (i) The Credentialing Committee shall meet prior to the MAC committee quarterly to be able to provide a report of recommendations to finalise all application within the standards 90 Days.
- (b) The quorum for a meeting of the Credentialing Committee shall be 3 members including **ONE** Medical Practitioner
- (c) The Chief Executive Officer, upon the request of the Chairman or any three Members, convene an additional meeting of the Medical Advisory Committee with at least three days' notice required for such a meeting.

- (d) The Chairman of the Medical Advisory Committee will serve as Chairman of the Credentialing committee.

11. Terms and Conditions and Process for appointment and re-appointment

11.1 Entitlement to treat Patients at the Hospital

- (a) The decision to grant access to facilities for the treatment and care of a Medical Practitioner's Patients is on each occasion within the sole discretion of the Board or Chief Executive Officer and the grant of Accreditation contains no conferral of a general expectation of or 'right of access'.
- (b) A Medical Practitioner's use of the Hospital's facilities for the treatment and care of Patients is limited to the Scope of Practice recommended by the Medical Advisory Committee and granted by the Board and subject to the conditions upon which the Scope of Practice is granted, resource limitations, and Organisational Need and Organisational Capability.

11.2 Terms and Conditions for all Accredited Practitioners or Practitioner seeking Appointment

Accredited Practitioners must:

- (a) comply with their authorised Scope of Clinical Practice;
- (b) comply with their responsibilities under the National Law in regard to mandatory notification of notifiable conduct by another practitioner or a student undertaking clinical training where the Accredited Practitioner has formed a reasonable belief that a health practitioner has behaved in a way that constitutes notifiable conduct in relation to the practice of their profession or suffers from an impairment that may place the public at substantial risk of harm.
- (c) comply with these By-Laws, rules and policies and procedures of the Hospital;
- (d) maintain their professional registration with AHPRA and furnish annually to the Hospital when requested to do so, evidence of registration and advise the CEO immediately of any material changes to the conditions or status of their professional registration (including suspension or termination);
- (e) Attend patients subject to the limits of any Conditions imposed by the CEO;
- (f) if theatre sessions have been requested by the Accredited Practitioner and allocated, then the Accredited Practitioner must effectively utilise the theatre sessions;
- (g) observe all requests made by the Hospital with regard to his or her conduct in the Facility and with regard to the provision of services within the Hospital;
- (h) adhere to the generally accepted ethics of medical or dental practice, including the ethical codes and codes of good medical practice of the Australian Medical Association and the Australian Dental Association (as applicable) and all relevant standards or guides issued by the Medical and Dental Boards of Australia as issued from time to time in relation to his or her colleagues, Hospital employees and patients;

- (i) adhere to general Conditions of clinical practice applicable at the Hospital, including compliance with the accreditation standards of the National Safety and Quality Health Service Standards (second edition) 2018 or such other accreditation body nominated by the Hospital;
- (j) observe the rules and practices of the Hospital in relation to the admission, discharge and accommodation of patients;
- (k) attend and, when reasonably required by the CEO, prepare for and participate in relevant clinical meetings, seminars, lectures and other teaching/training programs organised by the Hospital or provide evidence of attendance of these at alternative venues;
- (l) participate in Clinical Review Committee meetings, including review of clinical data and outcomes and respond to requests for information regarding statistical outliers, adverse events and cases flagged in incidents, clinical indicator or key performance indicator reporting;
- (m) seek relevant approvals from the relevant Committee and, where applicable, the relevant research and ethics Committee in regard to any research, experimental or innovative treatments, including any new or revised technology
- (n) not aid or facilitate the provision of medical or dental care to patients at the Facility by Medical Practitioners or Dental Practitioners who are not Accredited Practitioners;
- (o) not purport to represent Western Private Hospital in any circumstances, including the use of the letterhead of the Hospital unless with the express written permission of the CEO;
- (p) subject to the requirement of relevant laws, keep confidential details of all information which comes to his or her knowledge concerning patients, clinical practice, quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services; and
- (q) co-operate with and participate in any clinical quality assurance, quality improvement or risk management process, project or activities as required by the Hospital and these By-Laws.

Process for Initial Accreditation and Re-Accreditation as Medical Practitioners

- (a) Applications must include an acknowledgement by ticking on the tick box on the declaration form by the Medical Practitioner to the effect that the information provided by the Medical Practitioner is true and correct, and that the Medical Practitioner will comply in every respect with the By-Laws in the event that the Medical Practitioner's application for Accreditation is approved.
- (b) Applications for Initial Accreditation (where the applicant does not currently hold Accreditation at the Hospital) and Re-Accreditation (where the applicant currently holds Accreditation at the Hospital) as Medical Practitioners must be made via the online or mobile application form on CGOV
 - © All questions on the application form must be fully completed and all required information and documents supplied before an application will be considered. This will include:

Initial accreditation

- Proof of identity based on a 100 points check of original documents
- Current police check valid within last 12 months
- International police check if the applicant has lived overseas for 12 months or longer during the past 10 years
- Working with children check (if applicable)
- Original qualifications or certified copy including the primary medical degree
- Original or certified copy of specialist qualification
- Procedural qualifications
- Medical registration including current AHPRA registration confirming presence or absence of conditions, undertakings, endorsements, notations, and reprimands. Confirmation of type of registration (general or specialist)
- Medical indemnity insurance including original or certified copy ensuring the cover reflects the requested scope of practice.
- Continuing Professional Development (CPD) statements that are college approved or relevant to the scope of clinical practice
- Current curriculum vitae
- Referee checks including two referees who work largely within the Craft group of the applicant and have been in apposition to judge the practitioners experience during the previous three years.
 - (i) The requirements for applications will be as determined by the Credentialing from time to time and may be set out in a Medical Credentialing Policy. The requirements set out in the Cardiac Society Guidelines for credentialing of Cardiac Practitioners shall be considered.
 - (ii) Applications for Medical Credentialing will be considered based on the needs and resources of the Hospital. Consideration shall be made in line with the Hospitals current business plans and long term strategic plan.
 - (iii) Applications should be forwarded to the Credentialing Officer at least 60 days prior to the Medical Practitioner seeking to commence at the Hospital or at least 60 days prior to expiration of the current Accreditation. Where this timeframe is unable to be achieved due to Organisational needs or patient needs, Temporary Accreditation or Emergency Accreditation will be considered at the discretion of the Chief Executive Officer.
 - (iv) The Chief Executive Officer may interview Medical Practitioners and/or request further information from applicants that they consider appropriate.
 - (v) The Chief Executive Officer, in collaboration with the credentialing officer will ensure that applications are complete and requests for further information complied with, and upon being satisfied, will refer applications, together with notes from any interviews conducted and observations from the interview, to the Credentialing Committee.

Consideration of Applications for initial Accreditation by the Medical Advisory Committee

- (vi) The Medical Advisory Committee will consider all applications for Accreditation and Re-Accreditation referred to it by the Credentialing Committee. Consideration by the Medical Advisory Committee will include but not be limited to information relevant to Credentials, Competence and Current Fitness. The Medical Advisory Committee will make recommendations to the Board as to whether the applications should be approved and if so, on what terms, the Scope of Practice to be granted and whether to grant Accreditation with Admitting Rights or without Admitting Rights.
- (vii) In instances where the Medical Advisory Committee has doubts about a Medical Practitioner's ability to perform the services, procedures or other interventions which may have been requested for inclusion in the Scope of Practice, they may recommend to:

initiate an Internal Review for Re-Accreditation Applications;

initiate an External Review for Re-Accreditation Applications;

grant Scope of Practice for a limited period of time followed by review;

apply conditions or limitations to the Scope of Practice requested; and/or

apply requirements for relevant clinical services, procedures or other interventions to be performed under supervision or monitoring.

- (viii) If the Medical Practitioner's Credentials and assessed Competence and performance do not meet the Threshold Credentials (if any), the Medical Advisory Committee may recommend refusal of the application.
- (ix) In the event that the information or documents requested by the Medical Advisory Committee is not supplied in the time set out in the letter, the Medical Advisory Committee may, at its discretion, reject the application or proceed to consider the application without such additional information.
- (x) The Chief Executive Officer, as delegate of the Medical Advisory Committee, will forward a letter to the Medical Practitioner advising the Medical Practitioner whether the application has been approved or rejected. If the application has been approved, the letter will also contain details of the Scope of Practice granted, any terms and conditions, and whether the Medical Practitioner has been granted Accreditation with Admitting Rights or Accreditation without Admitting Rights at the Hospital.
- (xi) There is no right of appeal from a decision to reject an initial application for Accreditation.

(c) Initial Accreditation Tenure

- (i) Initial Accreditation as a Medical Practitioner at the Hospital, and Scope of Practice granted, will be for a probationary period of one year. Within one month prior to the end of the probationary period, a review of the Medical Practitioner's level of Competence, Current Fitness, Performance, compatibility with Organisational Capability and Organisational Need, and confidence in the Medical Practitioner will be undertaken by the Chief Executive Officer may seek assistance with the review from the Credentialing Committee. The CEO may initiate a review at any time during the probationary period where concerns arise about Performance, Competence, Current Fitness of, or confidence in the

Medical Practitioner, or there is evidence of Behavioural Sentinel Events exhibited by the Medical Practitioner.

(ii) In circumstances where, in respect of a Medical Practitioner:

a review conducted at the end of the probationary period, or a review conducted during the probationary period, causes the Chief Executive Officer to consider:

the Medical Practitioner's Scope of Practice should be amended, or

the probationary period should be terminated, or

the probationary period should be extended, or

the Medical Practitioner should not be offered Re-accreditation,

the Medical Practitioner will be:

notified of the circumstances which have given rise to the relevant concerns, and

be given an opportunity to be heard and present his/her case.

(iii) Should the Medical Practitioner have an acceptable probationary Accreditation review outcome, the Chief Executive Officer may decide to grant an additional Accreditation period of up to three years, on receipt of a signed declaration from the Medical Practitioner describing any specific changes, if any, to the initial information provided and ongoing compliance with all requirements as per the By-laws.

(iv) Should the probationary Accreditation review outcome be unacceptable to the Chief Executive Officer, it may:

amend the Scope of Practice granted; or

reject the Accreditation and provide documented reasons for the decision.

(v) The Medical Advisory Committee will make a final determination on Accreditation for all Medical Practitioners at the end of the probationary period. There will be no right of appeal at the end of the probationary period and all Medical Practitioners shall agree with this as a condition of initial appointment.

11.3 Re-Accreditation

(a) The Credentialing Officer will, at 90 days prior to the expiration of any term of Accreditation of each Medical Practitioner (other than a probationary period), alert that Medical Practitioner. Any Medical Practitioner wishing to be Re-Accredited must complete the application form via CGOV online form or mobile app at least 60 days prior to the expiration date of the Medical Practitioner's current term of Accreditation. All questions on the application form must be fully completed and all required information and documents supplied before an application will be considered. This will include:

- Working with children check (if applicable)
- Medical registration including current AHPRA registration confirming presence or absence of conditions, undertakings, endorsements, notations, and reprimands. Confirmation of type of registration (general or specialist)
- Medical indemnity insurance including original or certified copy ensuring the cover reflects the requested scope of practice.
- Continuing professional development (CPD) statements that are college approved or relevant to the scope of clinical practice

- Current curriculum vitae

- (b) The rights of appeal conferred upon Medical Practitioners who apply for Re-Accreditation as Medical Practitioners are set out in these By-Law.

11.4 Re-Accreditation tenure

Granting of Accreditation and Scope of Practice subsequent to the probationary period will be for a term of up to three years, as determined by the Board.

11.5 Nature of appointment of Visiting Medical Practitioners

- (a) Accreditation as a Visiting Medical Practitioner does not constitute an employment contract nor does it establish a contractual relationship between the Visiting Medical Practitioner and the Hospital.
- (b) Accreditation is personal and cannot be transferred to, or exercised by, any other person.
- (c) For Accredited Practitioners who have a medical practice company, the grant of Accreditation will be made only to the individual practitioner and not the company.

12. Extraordinary Accreditation

12.1 Temporary Accreditation

- (a) The CEO, MAC Chairperson, MAC member for the applicants' specialty may grant Medical Practitioners Temporary Accreditation and Scope of Practice on terms and conditions considered appropriate by the Chief Executive Officer. Temporary Accreditation will only be granted on the basis of Patient need, Organisational Capability and Organisational Need. The Chief Executive Officer/DON may consider Emergency Accreditation for short notice requests.
- (b) Applications for Temporary Accreditation as Medical Practitioners must be selected on the online – mobile application. All questions on the online form must be fully completed and required information and documents submitted before an application will be considered.
- (c) Temporary Accreditation may be terminated by the Chief Executive Officer for failure by the Medical Practitioner to comply with the requirements of the By-laws or a failure to comply with the Temporary Accreditation requirements.
- (d) Temporary Accreditation will automatically cease upon a determination by the Board of the Medical Practitioner's application for Accreditation or at such other time following such determination as the Chief Executive Officer decides.
- (e) The period of Temporary Accreditation shall be determined by the Chief Executive Officer, which will be for a period of no longer than three (3) months.
- (f) The Medical Advisory Committee will be informed of all Temporary Accreditation granted.
- (g) There will be no right of appeal from decisions relating to the granting of Temporary Accreditation or termination of Temporary Accreditation.
- (h) Temporary Accreditation does not create a right or expectation of full accreditation at a later date.

12.2 Emergency Accreditation

- (a) In the case of an emergency, any Medical Practitioner, to the extent permitted by the terms of the Medical Practitioner's registration, may request Emergency Accreditation and granting of Scope of Practice in order to continue the provision of treatment and care to Patients.

Emergency Accreditation may be considered by the Chief Executive Officer or Director of Nursing for short notice requests, to ensure continuity and safety of care for Patients and/or to meet Organisational Need.

- (b) As a minimum, the following is required within a reasonable time:
- (i) verification of identity through inspection of relevant documents (e.g. driver's licence with photograph);
 - (ii) immediate contact with a member of senior management of an organisation nominated by the Medical Practitioner as their most recent place of Accreditation to verify employment or appointment history;
 - (iii) verification of professional registration and insurance;
 - (iv) confirmation of at least one professional referee of the Medical Practitioner's Competence and good standing.

Verification will be undertaken by the Chief Executive Officer or Director of Nursing and will be fully documented.

- (c) Emergency Accreditation will be followed as soon as practicable with Temporary Accreditation or Initial Accreditation application processes, if required. Emergency Accreditation will be approved for a limited period as identified by the Chief Executive Officer, for the safety of Patients involved, and will automatically terminate at the expiry of that period or as otherwise determined by the Chief Executive Officer.
- (d) The Medical Advisory Committee will be informed of all Emergency Accreditations.
- (e) There will be no right of appeal from decisions on granting, or termination, of Emergency Accreditation.

13. Variation of Accreditation or Scope of Practice

13.1 Practitioner may request amendment of Accreditation or Scope of Practice

- (a) An Accredited Medical Practitioner may apply for an amendment or variation of their existing Scope of Practice or any term or condition of their Accreditation, other than in relation to the general terms and conditions applying to all Accredited Practitioners as provided in these By-laws.
- (b) The process for amendment or variation is the same for an application for Re-Accreditation, except the Medical Practitioner will be required to complete a Change Scope of Practice Form and provide relevant documentation and references in support of the amendment or variation.
- (c) The rights of appeal conferred upon Medical Practitioners who apply for amendment or variation are set out in these By-Laws, except an appeal is not available for an application made during a probationary period, or in relation to Temporary Accreditation, Emergency Accreditation, or a Locum Tenens.

14. Review of Accreditation or Scope of Practice

14.1 Authorised Person may initiate review of Accreditation or Scope of Practice

- (a) The Chief Executive Officer may at any time initiate a review of a Medical Practitioner's Accreditation or Scope of Practice where an allegation or concern is raised

- (b) The Chief Executive Officer will determine whether the process to be followed is an;
 - (i) Internal Review; or
 - (ii) External Review.
- (c) Prior to determining whether an Internal Review or External Review will be conducted, a representative of the Chief Executive Officer may, in their absolute discretion, meet with the Medical Practitioner, along with any other persons the Chief Executive Officer considers appropriate, advise of the concern or allegation raised, and invite a preliminary response from the Medical Practitioner (in writing or orally as determined by the Chief Executive Officer) before the Board or Chief Executive Officer makes a determination whether a review will proceed, and if so, the type of review.
- (d) The Accredited Practitioner shall be notified in writing by the Chief Executive Officer of the intent to conduct a review. A copy of these Bylaws shall be forwarded to the Medical Practitioner. The Medical Practitioner shall be invited to make a submission in response to the review.
- (e) A decision on whether an internal or external review shall be made by the Chief Executive Officer and the Medical Practitioner shall be notified.
- (f) The review may have wider terms of reference than a review of the Medical Practitioner's Accreditation or Scope of Practice.
- (g) The Chief Executive Officer must make a determination whether to impose an interim suspension or conditions upon the Accreditation of the Medical Practitioner pending the outcome of the review in accordance with the relevant provisions of these By-laws.
- (h) In addition or as an alternative to conducting an internal or external review, the Chief Executive Officer will notify the Medical Practitioner's registration board and/or other professional body responsible for the Medical Practitioner of details of the concerns raised if required by legislation, otherwise the Chief Executive Officer may notify if they consider it is in the interests of Patient care or safety to do so, it is in the interests of protection of the Public (including patients at other facilities) to do so, or it is considered that the registration board or professional body is more appropriate to investigate and take necessary action. Following the outcome of any action taken by the registration board and/or other professional body the Chief Executive Officer may elect to take action, or further action, under these By-laws.
- (i) The Chief Executive Officer shall refer all these matters to the Medical Director The Medical Director shall make all final decisions regarding whether to continue (including with conditions), amend, suspend or terminate the Medical Practitioners accreditation.
- (j) The Chief Executive Officer shall advise the Accredited Practitioner in writing within five working days of the review decision and shall implement the decision immediately.

14.2 Internal Review of Accreditation and Scope of Practice

- (a) The Chief Executive Officer will establish the terms of reference of the Internal Review, and may seek assistance from representatives of the Medical Advisory Committee or co-opted Medical Practitioners or personnel from within the Hospital who bring specific expertise to the Internal Review as determined by the Board or Chief Executive Officer.
- (b) The terms of reference, process, and reviewers will be as determined by the Chief Executive Officer. The process will ordinarily include the opportunity for submissions from the Medical Practitioner, which may be written and/or oral.

- (c) The Chief Executive Officer will notify the Medical Practitioner in writing of the review, the terms of reference, process and reviewers.
- (d) A detailed report on the findings of the review in accordance with the terms of reference will be provided by the reviewers to the Chief Executive Officer.
- (e) Following consideration of the report, the Board or Chief Executive Officer is required to make a determination of whether or not to continue (including with conditions), amend, suspend or terminate a Medical Practitioner's Accreditation in accordance with the By-laws.
- (f) The Chief Executive Officer must notify the Medical Practitioner in writing of the determination made in relation to the Accreditation, the reasons for it, and advise of the right of appeal, the appeal process and the timeframe for an appeal.
- (g) The Medical Practitioner shall have the rights of appeal established by these By-laws in relation to the final determination made by the Board or Chief Executive Officer if a decision is made to amend, suspend, terminate or impose conditions on the Medical Practitioner's Accreditation.
- (h) In addition or as an alternative to taking action in relation to the Accreditation follow receipt of the report, Chief Executive Officer will notify the Medical Practitioner's registration board and/or other professional body responsible for the Medical Practitioner of details of the concerns raised and outcome of the review if required by legislation, otherwise the Chief Executive Officer may notify if they consider it is in the interests of Patient care or safety to do so, it is in the interests of protection of the Public (including patients at other facilities) to do so, it is considered appropriate that the registration board or professional body consider the matter, or it should be done to protect the interests of the Hospital.

14.3 External Review of Accreditation and Scope of Practice

- (a) The Chief Executive Officer will make a determination about whether an External Review will be undertaken.
- (b) An External Review will be undertaken by a person(s) external to the Hospital and of the Accredited Medical Practitioner in question and such person(s) will be nominated by the Chief Executive Officer at their discretion.
- (c) The terms of reference, process, and reviewers will be as determined by the Chief Executive Officer. The process will ordinarily include the opportunity for submissions from the Medical Practitioner, which may be written and/or oral.
- (d) The Chief Executive Officer will notify the Medical Practitioner in writing of the review, the terms of reference, process and reviewers.
- (e) The external reviewer is required to provide a detailed report on the findings of the review in accordance with the terms of reference to the Chief Executive Officer.
- (f) The Medical Director, Chief Executive Officer and one Member from the Board of Management will review the report from the External Review and make a determination of whether to continue (including with conditions), amend, suspend or terminate the Medical Practitioner's Accreditation or Scope of Practice in accordance with these By-Laws.
- (g) The Chief Executive Officer must notify the Medical Practitioner in writing of the determination made in relation to the Accreditation, the reasons for it, and advise of the right of appeal, the appeal process and the timeframe for an appeal.
- (h) The Medical Practitioner shall have the rights of appeal established by these By-Laws in relation to the final determination made by the Medical Director, Chief Executive Officer and

Board member; if a decision is made to amend, suspend, terminate or impose conditions on the Medical Practitioner's Accreditation.

- (i) In addition or as an alternative to taking action in relation to the Accreditation follow receipt of the report, the Chief Executive Officer will notify the Medical Practitioner's registration board and/or other professional body responsible for the Medical Practitioner of details of the concerns raised and outcome of the review if required by legislation, otherwise the Chief Executive Officer may notify if they consider it is in the interests of Patient care or safety to do so, it is in the interests of protection of the Public (including patients at other facilities) to do so, it is considered appropriate that the registration board or professional body consider the matter, or it should be done to protect the interests of the Hospital.

15. Suspension, termination, imposition of conditions, resignation and expiry of Accreditation

15.1 Suspension of Accreditation or Scope of Practice

The CEO, following consultation with the Medical Director, may by notice in writing suspend (in part or in full) the Accreditation of an Accredited Practitioner until further notice if in the opinion of the CEO:

- to do so would be in the interests of patient care or safety;
- to do so would be in the interests of staff welfare or safety;
- the Accredited Practitioner has materially breached any conditions of Accreditation, including failing to comply with these By-Laws;
- the conduct of the Accredited Practitioner compromises the efficient operation or the interests of the Facility;
- the conduct of the Accredited Practitioner is likely to harm the reputation of the Facility and/or of Western Private Hospital
- serious and unresolved issues of concern have been raised in relation to the Accredited Practitioner.

- (a) As an alternative to an immediate suspension, the Medical Director or Chief Executive Officer may elect to deliver a show cause notice to the Medical Practitioner advising of:
 - (i) the facts and circumstances forming the basis for possible suspension;
 - (ii) the grounds under the By-Laws upon which suspension may occur;
 - (iii) invite a written response from the Medical Practitioner, including a response why the Medical Practitioner may consider suspension is not appropriate;
 - (iv) if applicable and appropriate in the circumstances, any actions that must be performed for the suspension not to occur and the period within which those actions must be completed; and
 - (v) a timeframe in which a response is required from the Medical Practitioner to the show cause notice;

Following receipt of the response the Medical Director or Chief Executive Officer will determine whether the Accreditation will be suspended. If suspension is to occur notification will be sent Otherwise the Medical Practitioner will be advised that

suspension will not occur, however this will not prevent the Medical Director or Chief Executive Officer from taking other action at this time, including imposition of conditions, and will not prevent the Medical Director or Chief Executive Officer from relying upon these matters as a ground for suspension or termination in the future.

- (b) The suspension is ended either by terminating the Accreditation or lifting the suspension. This will occur by written notification by the Medical Director or Chief Executive Officer.
- (c) The affected Medical Practitioner shall have the rights of appeal established by these By-laws.
- (d) If there is held, in good faith, a belief that the matters forming the grounds for suspension give rise to a significant concern about the safety and quality of health care provided by the Medical Practitioner including but not limited to patients outside of the Hospital, it is in the interests of Patient care or safety to do so, it is in the interests of protection of the Public (including patients at other facilities) to do so, it is required by legislation, or for other reasonable grounds, the Medical Director or Chief Executive Officer will notify the Medical Practitioner's registration board and/or other relevant regulatory agency of the suspension and the reasons for it.

15.2 Termination of Accreditation or Scope of Practice

- (a) Accreditation shall be immediately terminated by the Medical Director or Chief Executive Officer if the following has occurred, or if it appears based upon the information available to the Medical Director or Chief Executive Officer the following has occurred:
 - (i) the Medical Practitioner ceases to be registered with their relevant registration board;
 - (ii) the Medical Practitioner ceases to maintain and provide a certificate to the hospital of Adequate Professional Indemnity Insurance covering the Scope of Practice; or
 - (iii) a contract of employment or to provide services is terminated or ends, and is not renewed.
- (b) Accreditation may be terminated by the Medical Director or Chief Executive Officer if the following has occurred, or if it appears based upon the information available to the Medical Director or Chief Executive Officer the following has occurred:
 - (i) based upon any of the matters in By-Law 15.1(a) and it is considered suspension is an insufficient response in the circumstances;
 - (ii) based upon a finalised Internal Review or External Review pursuant to these By-laws and termination of Accreditation is considered appropriate in the circumstances or in circumstances where the Medical Director or Chief Executive Officer does not have confidence in the continued appointment of the Medical Practitioner;
 - (iii) the Medical Practitioner is not regarded by the Medical Director or Chief Executive Officer as having the appropriate Current Fitness to retain Accreditation or the Scope of Practice, or the Medical Director or Chief Executive Officer does not have confidence in the continued appointment of the Medical Practitioner;
 - (iv) conditions have been imposed by the Medical Practitioner's registration board on clinical practice that restricts practice and the Hospital does not have capacity to meet the results of the conditions imposed;

- (v) the Medical Practitioner has not exercised Accreditation or utilised the facilities at the Hospital for a continuous period of 12 months, or at a level or frequency as otherwise specified to the Medical Practitioner by the MAC;
 - (vi) the Scope of Practice is no longer supported by Organisational Capability or Organisational Need;
 - (vii) the Medical Practitioner is engaged in conduct that in the opinion of the Medical Director or CEO will bring harm to the reputation of the hospital
 - (viii) the Medical Practitioner becomes permanently incapable of performing his/her duties which shall for the purposes of these By-laws be a continuous period of six months' incapacity; or
 - (ix) there are other unresolved issues or other concerns in respect of the Medical Practitioner that is considered to be a ground for termination.
- (c) The Accreditation of a Medical Practitioner may be terminated as otherwise provided in these By-laws.
- (d) The Medical Director or Chief Executive Officer shall provide a copy of these Bylaws to, and notify the Medical Practitioner of:
- (i) the fact of the termination;
 - (ii) the reasons for the termination;
 - (iii) if the Medical Director or Chief Executive Officer considers it applicable and appropriate in the circumstances, invite a written response from the Medical Practitioner why they may consider a termination should not have occurred; and
 - (iv) if a right of appeal is available in the circumstances, the right of appeal, the appeal process and the time frame for an appeal.
- (e) As an alternative to an immediate termination, the Medical Director or Chief Executive Officer may elect to deliver a show cause notice to the Medical Practitioner advising of:
- (i) the facts and circumstances forming the basis for possible termination;
 - (ii) the grounds under the By-Laws upon which termination may occur;
 - (iii) invite a written response from the Medical Practitioner, including a response why the Medical Practitioner may consider termination is not appropriate;
 - (iv) if applicable and appropriate in the circumstances, any actions that must be performed for the termination not to occur and the period within which those actions must be completed; and
 - (v) a timeframe in which a response is required from the Medical Practitioner to the show cause notice;

Following receipt of the response the Medical Director or Chief Executive Officer will determine whether the Accreditation will be terminated. If termination is to occur notification will be sent in accordance with paragraph (d). Otherwise the Medical Practitioner will be advised that termination will not occur, however this will not prevent the Medical Director or Chief Executive Officer from taking other action at this time, including imposition of conditions, and will not prevent the Medical Director or Chief Executive Officer from relying upon these matters as a ground for suspension or termination in the future.

- (f) For a termination of Accreditation pursuant to By-law 15.2(a), there shall be no right of appeal.
- (g) For a termination of Accreditation pursuant to By-law 15.2(b), the Medical Practitioner shall have the rights of appeal established by these By-laws.
- (h) Unless it is determined not appropriate in the particular circumstances, the fact and details of the termination will be notified by the Medical Director or Chief Executive Officer to the Medical Practitioner's registration board and/or other relevant regulatory agency.

15.3 Imposition of conditions

- (a) At the conclusion of or pending finalisation of a review pursuant to By-law 14 or in lieu of a suspension pursuant to By-law 15.1 or in lieu of a termination pursuant to By-law 15.2 the Medical Director or Chief Executive Officer may elect to impose conditions on the Accreditation or Scope of Practice.
- (b) The Medical Director or Chief Executive Officer must notify the Medical Practitioner in writing of the imposition of conditions, the reasons for it, the consequences if the conditions are breached, and advise of the right of appeal, the appeal process and the timeframe for an appeal. If the Medical Director or Chief Executive Officer considers it applicable and appropriate in the circumstances, they may also invite a written response from the Medical Practitioner as to why the Medical Practitioner may consider the conditions should not be imposed.
- (c) If the conditions are breached, then suspension or termination of Accreditation may occur, as determined by the Medical Director or Chief Executive Officer.
- (d) The affected Medical Practitioner shall have the rights of appeal established by these By-laws.
- (e) If there is held, in good faith, a belief that the continuation of the unconditional right to practise in any other organisation would raise a significant concern about the safety and quality of health care for patients and the public, the Medical Director or Chief Executive Officer will notify the Medical Practitioner's registration board and/or other relevant regulatory agency of the imposition of the conditions and the reasons the conditions were imposed.

15.4 Resignation and expiry of Accreditation

A Medical Practitioner may resign his/her Accreditation by giving one month's notice of the intention to do so to the Chief Executive Officer, unless a shorter notice period is otherwise agreed by the Chief Executive Officer.

A Medical Practitioner who intends ceasing treating Patients either indefinitely or for an extended period must notify his/her intention to the Chief Executive Officer, and Accreditation will be taken to be withdrawn one month from the date of notification unless the Chief Executive Officer decides a shorter notice period is appropriate in the circumstances.

If an application for Re-Accreditation is not received within the timeframe provided for in these By-laws, unless determined otherwise by the Chief Executive Officer, the Accreditation will expire at the conclusion of its term. If the Medical Practitioner wishes to admit or treat Patients at the Hospital after the expiration of Accreditation, an application for Accreditation must be made as an application for Initial Accreditation.

If the Medical Practitioner's Scope of Practice is no longer supported by Organisational Capability or Organisational Need, if the Medical Practitioner will no longer be able to meet the terms and conditions of Accreditation, or where admission of Patients or utilisation of services at the Hospital is regarded by the Board to be insufficient, the Chief Executive Officer will raise these matters in writing with the Accredited Practitioner and invite a meeting to discuss,

following which the Chief Executive Officer and Accredited Practitioner may agree that Accreditation will expire and they will agree on the date for expiration of Accreditation. Following the date of expiration, if the Medical Practitioner wishes to admit or treat Patients at the Hospital, an application for Accreditation must be made as an application for Initial Accreditation.

The provisions in relation to resignation and expiration of Accreditation in no way limit the ability of the Chief Executive Officer to take action pursuant to other provisions of these By-laws, including by way of suspension or termination of Accreditation.

16. Appeal rights and procedure

16.1 Rights of appeal against decisions affecting Accreditation

- (a) There shall be no right of appeal against a decision to not approve initial, temporary, emergency or locum Accreditation, or continued Accreditation at the end of a probationary period or temporary, emergency or locum Accreditation period.
- (b) Subject to paragraph a) above, a Medical Practitioner shall have the rights of appeal as set out in these By-Laws.

16.2 Appeal process

- (a) A Medical Practitioner shall have fourteen (14) days from the date of notification of a decision to which there is a right of appeal in these By-Laws to lodge an appeal against the decision.
- (b) An appeal must be in writing to the Chief Executive Officer and received by the Chief Executive Officer within the fourteen (14) day appeal period or else the right to appeal is lost.
- (c) Unless decided otherwise by the Board in the circumstances of the particular case, which will only be in exceptional circumstances, lodgement of an appeal does not result in a stay of the decision under appeal and the decision will stand and be actioned accordingly.
- (d) The Board will nominate an Appeal Committee to hear the appeal, establish terms of reference, and submit all relevant material to the chairperson of the Appeal Committee.
- (e) The Appeal Committee shall comprise at least three (3) persons and will include:
 - (i) a nominee of the Board, who may be an Accredited Practitioner, who must be independent of the decision under appeal regarding the Medical Practitioner, and who will be the chairperson of the Appeal Committee;
 - (ii) a nominee of the Medical Advisory Committee, who may be an Accredited Practitioner, who must be independent of the decision under appeal regarding the Medical Practitioner;
 - (iii) a nominee of the professional college or an independent from the Medical Practitioners speciality group.
 - (iv) The Medical Director/ Board representative shall Chair the Appeal Committee
- (f) Before accepting the appointment, the nominees will confirm that they do not have a known conflict of interest with the appellant and will sign a confidentiality agreement. Once all members of the Appeal Committee have accepted the appointment, the Chief Executive Officer will notify the appellant of the members of the Appeal Committee.
- (g) Unless a shorter timeframe is agreed by the appellant and the Appeal Committee, the appellant shall be provided with at least 14 days notice of the date for determination of the appeal by the Appeal Committee. The notice from the Appeal Committee will ordinarily set

out the date for determination of the appeal, the members of the Appeal Committee, the process that will be adopted, and will invite the appellant to make a submission about the decision under appeal. Subject to an agreement to confidentiality from the appellant, the chairperson may provide the appellant with copies of material to be relied upon by the Appeal Committee.

- (h) The appellant will be given the opportunity to make a submission to the Appeal Committee. The Appeal Committee shall determine whether the submission by the appellant may be in writing or in person or both.
- (i) If the appellant elects to provide written submissions to the Appeal Committee, following such a request from the Appeal Committee for a written submission, unless a longer time frame is agreed between the appellant and Appeal Committee the written submission will be provided within 7 days of the request.
- (j) The Chief Executive Officer (or nominee) may present to the Appeals Committee in order to support the decision under appeal.
- (k) If the appellant attends before the Appeal Committee to answer questions and to make submissions, the appellant is not entitled to have formal legal representation at the meeting of the Appeal Committee. The appellant is entitled to be accompanied by a support person, who may be a lawyer, but that support person is not entitled to address the Appeal Committee.
- (l) The appellant shall not be present during Appeal Committee deliberations except when invited to be heard in respect of his/her appeal.
- (m) The chairperson of the Appeal Committee shall determine any question of procedure for the Appeal Committee, with questions of procedure entirely within the discretion of the chairperson of the Appeal Committee.
- (n) The Appeal Committee will make a written recommendation regarding the appeal to the Board, including provision of reasons for the recommendation. The recommendation may be made by a majority of the members of the Appeal Committee and if an even number of Appeal Committee members then the chairperson has the deciding vote. A copy of the recommendation will be provided to the appellant.
- (o) The Medical Advisory Committee will consider the recommendation of the Appeal Committee and make a decision about the appeal.
- (p) The decision of the Appeals Committee will be notified in writing to the appellant.
- (q) The decision of the Appeals Committee is final and binding, and there is no further appeal allowed under these By-Laws from this decision.
- (r) If a notification has already been given to an external agency, such as a registration Board, then the Chief Executive Officer will notify that external agency of the appeal decision. If a notification has not already been given, the Medical Advisory Committee will make a determination whether notification should now occur based upon the relevant considerations for notification to an external agency as set out in these By-laws relating to the decision under appeal.

Part B– Accreditation of Dentists

17. Accreditation and Scope of Practice of Dentists

By-laws 9 to 16, so far as they are relevant and applicable, are hereby repeated in full substituting where applicable Visiting Dentist for Visiting Medical Practitioner and Dentist for Medical Practitioner.

Applications for Initial Accreditation and Re-Accreditation should be submitted on the approved form to the Chief Executive Officer.

Part C– Accreditation of Visiting Allied Health Professionals

18. Accreditation and Scope of Practice of Visiting Allied Health Professionals

Allied health registration and insurance are to be confirmed as current on an annual basis and the information is to be tabled at the MAC.

Issues of concern regarding Allied Health Professionals conduct or their ability to provide the service required of them shall be addressed with the Provider and the CEO. Where necessary these Providers shall have their contract terminated as per their contractual agreements

Part D – Amending By-laws, annexures, and associated policies and procedures

19. Amendments to, and instruments created pursuant to, the By-laws

- (a) Amendments to these By-laws can only be made by approval of the Board.
- (b) All Accredited Medical Practitioners, Dentists and Allied Health Professionals will be bound by amendments to the By-laws from the date of approval of the amendments by the Board, even if Accreditation was obtained prior to the amendments being made. If amendments are to have retrospective application, this must be specifically stated by the Board.
- (c) The Board may approve annexures that accompany these By-Laws, and amendments that may be made from time to time, and the annexures once approved by the Board are integrated with and form part of the By-Laws.
- (d) The Medical Advisory Committee may approve terms of reference and policies and procedures that are created pursuant to these By-Laws or to provide greater detail and guidance in relation to implementation of aspects of these By-Laws.
- (e) The Chief Executive Officer must review these By-Laws not less than every 5 years.