St Andrew's
HOSPITAL - TOOWOOMBA

By-Laws and Professional Guidelines for Medical Practitioners, Dentists and Allied Health Professionals

DEVELOPED FOR

MEMBERS OF THE
PRIVATE HOSPITALS ASSOCIATION OF QUEENSLAND
by Minter Ellison Lawyers

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1. Preface

St Andrew's Toowoomba Hospital is a 137-bed, acute care private hospital situated on the north-western side of Toowoomba. Established in 1966, the Hospital is a not-for-profit private hospital and a registered charity. All profits made by the Hospital are reinvested back into the Hospital to provide expansion of buildings, additional services, new equipment and staff training.

2. Vision and Values

MISSION STATEMENT

Excellence in Care and Service

VALUES

We strive to achieve with patients, visitors and staff:

- Respect
- Dignity
- Empathy
- Courtesy
- Fairness
- Honesty

Our services are at all times provided with caring support through ethical and legal professional practices.

OBJECTIVES

- Conduct and maintain Hospital activities in a manner that reflect Christian values.
- Provide quality services that achieve excellence in the delivery of patient care.
- Foster positive relationships with visiting medical staff and allied health professionals.
- Maintain a safe and comfortable physical environment for patients, visitors and staff.
- Manage human and material resources effectively and efficiently.
- Recruit and select staff into an environment that supports professional and personal development.
- Maintain and improve Hospital services and facilities that reflect contemporary developments in clinical practice.
- Develop, implement and manage appropriate information systems that support efficient management practices.
- Promote the role of the Hospital as an integral part of the community.
- Manage revenue of the Hospital so that resources are available for future development of facilities and services.

These values should be used to guide the application of the By-laws.

Part A – Definitions and introduction

3. Definitions and interpretation

3.1 Definitions

In these By-laws, unless indicated to the contrary or the context otherwise requires:

Accreditation means the process provided for in these By-laws by which a person is accredited. The two conditions for Accreditation are an explicit definition of quality (ie standards) and an independent review process aimed at identifying the level of congruence between practices and quality standards.

Accreditation Category means as part of Accreditation, the appointment of an Accredited Practitioner to one of more of the following categories: Allied Health Professional, Dentist, Employed Medical Officer, General Medical Practitioner, Specialist Medical Practitioner, Surgical Assistant – Medical Practitioner, Surgical Assistant – Non Medical Practitioner, Registrars or Advanced Trainees. The Board may from time to time approve other Accreditation Categories.

Accreditation Type means as part of Accreditation, the appointment of an Accredited Practitioner with one or more of the following: admitting privileges, allied health privileges, anaesthetic privileges, assist privileges, consulting privileges, contract of employment privileges, diagnostic privileges, procedural privileges, surgical assist privileges – medical practitioner, surgical assist privileges – non medical practitioner, and surgical privileges. The Board may from time to time approve other Accreditation Types.

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

Accredited Practitioner means a Medical Practitioner, Dentist, Allied Health Professional, Non Medical Practitioner or other practitioner who has been accredited to provide services within the Hospital within the Accreditation Category, Accreditation Type and Scope of Practice notified in the appointment.

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 Hospital, and is in an amount and on terms that the Hospital considers in its 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 Chief Executive Officer of the Hospital in accordance with the provisions of these By-laws.

Allied Health Professional means a person registered under the applicable legislation to practise as an Allied Health Professional.

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 or Hospital outcomes.

Board means the Board of Governors of the Hospital.

By-laws means these By-laws.

Chief Executive Officer means the person appointed to the position of Chief Executive Officer, or equivalent position by whatever name, 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.

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 their profession (as the case may be).

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

Director of Clinical Services means the person appointed to the position of Director of Clinical Services 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, Allied Health Professional or Non Medical Practitioner 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 St Andrew's Toowoomba 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.

Medical Director means the person appointed to the position of Medical Director or equivalent position by whatever name, of the Hospital or any person acting, or delegated to act, in that position.

Medical Practitioner means, for the purposes of these By-laws, a person registered under the applicable legislation to practise medicine.

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.

Non Medical Practitioner means, for the purposes of these By-laws, a person registered under applicable legislation to practice as a Registered Nurse, for purposes of surgical assisting.

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. This may be specified on the hospital licence to operate. Organisational Capability may also be referred to as service capability.

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.

Patient means a person admitted to, or treated t 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 initial period or any subsequent term.

Scope of Practice means the extent of an individual Accredited Practitioner's permitted 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. Scope of Practice may also be referred to as delineation of clinical privileges.

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 is registered under the applicable legislation to practise medicine in that speciality.

Temporary Accreditation means the process provided in 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 are to be approved by the Chief Executive Officer and may be incorporated into an Accreditation policy.

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 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.

3.2 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 Chief Executive Officer 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 Chief Executive Officer. There is no appeal from such a determination by the Chief Executive Officer.

3.3 Meetings

Where a reference is made to a meeting, the quorum requirements that will apply are those specified in the terms of reference of the relevant committee. If there are no terms of reference, where there is an odd number of members a quorum will be a majority of the members, or where there is an even number of members a quorum will be half of the number of the members plus one.

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). 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. Circular resolution means consensus from the majority of participants to an electronic communication.

Information provided to any committee or person shall be regarded as confidential and is not to be disclosed beyond the purpose for which the information was made available, subject to the exceptions set out in these By-laws.

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 subject to any agreed resolution on the matter shall take no part in any relevant discussion or resolution with respect to that particular matter. This will include a member the Medical Advisory Committee or Credentialing Committee whose application for Accreditation is being considered.

4. Introduction

4.1 Purpose of this document

(a) The By-laws provide direction to the Chief Executive Officer in relation to exercise of certain aspects of their managerial responsibility.

(b) Patient care is provided by Accredited Practitioners who have been granted access to use the Hospital in order to provide that care. The By-laws define the relationship and obligations between the Hospital and its Accredited Practitioners.

(c) This document sets out certain terms and conditions upon which Medical Practitioners, Dentists, Allied Health Professionals and Non Medical Practitioners 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.

(d) Every applicant for Accreditation will be given a copy of this document and Annexures before or at the time of making an application. It is expected that the By-laws are read in their entirety by the applicant as part of the application process.

(e) The Hospital aims to maintain a high standard of Patient care and to continuously improve the safety and quality of its services. The By-laws implement measures aimed at maintenance and improvements in safety and quality.

(f) Health care in Australia is subject to numerous legislation and standards. The By-laws assist in compliance with certain aspects of this regulation but are not a substitute for review of the relevant legislation and standards.

Part B – Terms and conditions of Accreditation

5. Compliance with By-laws

5.1 Compliance obligations

(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 at the Hospital.

(b) Any non-compliance with the By-laws may be grounds for suspension, termination, or imposition of conditions.

(c) Unless specifically determined otherwise by the Chief Executive Officer in writing for a specified Accredited Practitioner, the provisions of these By-laws in their entirety prevail to the extent of any inconsistency with any terms, express or implied, in a contract of employment or engagement that may be entered into. In the absence of a specific written determination by the Chief Executive Officer, it is a condition of ongoing Accreditation that the Accredited Practitioner agrees that the provisions of these By-laws prevail to the extent of any inconsistency or uncertainty between the provisions of these By-laws and any terms, express or implied, in a contract or employment or engagement.

5.2 Compliance with policies and procedures

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

5.3 Compliance with legislation

Accredited Practitioners must comply with all relevant legislation, including but not limited to legislation that relates to health, public health, drugs and poisons, aged care, privacy, coroners, criminal law, health practitioner registration, research, environmental protection, workplace health & safety, occupational health and safety, antidiscrimination, bullying, harassment, industrial relations, care of children, care of persons with a disability, substituted decision making and persons with impaired capacity, mental health, Medicare, health insurance, fair trading and trade practices, intellectual property, and other relevant legislation regulating the Accredited Practitioner, provision of health care or impacting upon the operation of the Hospital.

In addition, Accredited Practitioners must ensure compliance with, or assist the Hospital to comply with, any Commonwealth or State mandated service capability frameworks or minimum standards.

5.4 Insurance and registration

Accredited Practitioners must at all times maintain Adequate Professional Indemnity Insurance.

Accredited Practitioners must at all times maintain registration with their relevant health registration board (local and/or national) that regulates the provision of services in the State where the Hospital is located.

Accredited Practitioners are required to provide evidence annually, or at other times upon request, of Adequate 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. If further information is requested in relation to insurance or registration, the Accredited Practitioner will assist to obtain that information, or provide permission for the Hospital to obtain that information directly.

5.5 Standard of conduct and behaviour

(a) The Hospital expects a high standard of professional and personal conduct from Accredited Practitioners, who must conduct themselves at all times 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 Values of the Hospital;

(iv) the strategic direction of the Hospital;

(v) the limits of their registration or any conditions placed upon Scope of Practice in accordance with these By-laws; and

(vi) all reasonable requests made with regard to personal conduct in the Hospital.

(b) 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.

(c) Upon request by the Chief Executive Officer the Accredited Practitioner is required to meet with the Chief Executive Officer and any other person that the Chief Executive Officer may ask to attend the meeting, to discuss matters in a) or b) above, or any other matter arising out of these By-Laws.

5.6 Notifications

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

(a) an investigation or complaint 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, a health complaints body, or another statutory authority, State or Government agency;

(b) an adverse finding (including but not limited to criticism or adverse comment about the care or services provided by the Accredited Practitioner) be made against the Accredited Practitioner by a civil court, the practitioner's registration board, disciplinary body, Coroner, a health complaints body, or another statutory authority, State or Government agency, 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 Hospital, hospital or day procedure centre alter in any way, including if it is withdrawn, suspended, restricted, or made conditional, and irrespective of whether this was done by way of agreement;

(f) any physical or mental condition or substance abuse problem occur that could affect his or her ability to practise or that would require any special assistance to enable him or her to practise safely and competently;

(g) 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;

(h) the Accredited Practitioner believe that Patient care or safety is being compromised or at risk, or may potentially be compromised or at risk, by another Accredited Practitioner of the Hospital; or

(i) the Accredited Practitioner make a mandatory notification to a health practitioner registration board about another person clinically involved at the Hospital.

The Hospital expects the Accredited Practitioner to comply with these obligations.

5.7 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 Accreditation of the Accredited Practitioner;
(ii) the Scope of Practice of the Accredited Practitioner;
(iii) the ability of the Accredited Practitioner to safely deliver health services to his/her Patients within the Scope of Practice;
(iv) the Accredited Practitioner's registration or professional indemnity insurance arrangements;
(v) the inability of the Accredited Practitioner to satisfy a medical malpractice claim by a Patient;
(vi) adverse outcomes, complications or complaints in relation to the Accredited Practitioner's Patients (current or former) of the Hospital;
(vii) the reputation of the Accredited Practitioner as it relates to the provision of Clinical Practice; and
(viii) the reputation of the Hospital.

(b) Subject to restrictions directly relating to or impacting upon legal professional privilege or statutory obligations of confidentiality, every Accredited Practitioner must keep the Chief Executive Officer informed and updated about the commencement, progress and outcome of compensation claims, coronial investigations or inquests, police investigations, Patient complaints, health complaints body complaints or investigations, or other inquiries involving Patients of the Accredited Practitioner that were treated at the Hospital.

5.8 Representations and media

(a) Unless an Accredited Practitioner has the prior written consent of the Chief Executive Officer, an Accredited Practitioner may not use the Hospital's (which for the purposes of this provision includes a corporate or business name of the Hospital, its parent companies or subsidiary companies) name, letterhead, or in any way suggest that the Accredited Practitioner represents these entities.

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

5.9 Committees

(a) The Hospital requires Accredited Practitioners, as reasonably requested by the Chief Executive Officer, to assist it in achieving its goals and strategic direction, and provision of high level care and services, 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 of Medical Practitioners, Dentists and/or Allied Health Professionals.

5.10 Confidentiality

(a) Accredited Practitioners will manage all matters relating to the confidentiality of information in compliance with the Hospital's policy, the 'National Privacy Principles' established by the *Privacy Act (Cth),* and other legislation and regulations relating to privacy and confidentiality, and will not do anything to bring the Hospital 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 also be kept confidential by Accredited Practitioners:

(i) Commercial in confidence business information concerning the Hospital;

(ii) Information concerning the Hospital's insurance arrangements;

(iii) information concerning any Patient or staff of the Hospital;

(iv) 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.

5.11 Communication

Accredited Practitioners are required to familiarise themselves with the organisational structure of the Hospital.

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

Accredited Practitioners acknowledge and consent to communication between these persons and entities of information, including their own personal information that 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.

6. Safety and quality

6.1 Admission, availability, communication, & discharge

(a) Accredited Practitioners will admit and treat Patients only within the Accreditation Category, Accreditation Type and Scope of Practice granted, including any terms or conditions attached to the approval of Accreditation.

(b) Accredited Practitioners will not provide services or practice outside of the defined service capability of the Hospital.

(c) Accredited Practitioners who admit Patients to the Hospital for treatment and care accept that they are at all times responsible for the care of their Patient and must ensure that they are available to treat and care for those Patients at all times, or failing that, that other arrangements as permitted by the By-laws are put in place to ensure the continuity of treatment and care for those Patients.

(d) Accredited Practitioners must visit all Patients admitted or required to be treated by them as frequently as is required by the clinical circumstances of those Patients and as would be judged appropriate by professional peers. 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.

(e) 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.

(f) It is the responsibility of the Accredited Practitioner to ensure any changes to contact details are notified promptly to the Chief Executive Officer. 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.

(g) A locum must be approved 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.

(h) 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. Accredited Practitioners must at all times be aware of the importance of effective communication with other members of the health care team, referring doctors, the Hospital executive, Patients and the Patient's family or next of kin, and at all times ensure appropriate communication has occurred, adequate information has been provided, and questions or concerns have been adequately responded to.

(i) The Accredited Practitioner must appropriately supervise the care that is provided by the Hospital staff and other practitioners. This includes providing adequate instructions to, and

supervision of, Hospital staff to enable staff to understand what care the Accredited Practitioner requires to be delivered.

(j) Adequate instructions and clinical handover are 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.

(k) If care is transferred to another Accredited Practitioner, this must be noted on the Patient medical record and communicated to the Director of Clinical Services or other responsible nursing staff member.

(l) Accredited Practitioners 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) The Accredited Practitioner must ensure that their Patients are not discharged without the approval of the Accredited Practitioner, complying with the discharge policy of the Hospital and completing all Patient discharge documents required by the Hospital. Patients discharging themselves from the Hospital against the Accredited Practitioner's advice are required to complete the appropriate written declaration before leaving the Hospital.

6.2 Surgery

Accredited Practitioners must effectively utilise allocated theatre sessions that have been requested by the Accredited Practitioner.

Accredited Practitioners may only utilise as surgical assistants practitioners Accredited in accordance with these By-Laws.

Accredited Practitioners acknowledge the importance of, and will participate in, various measures aimed at ensuring safety and quality during surgery, which includes but is not limited to participating in or allowing to occur, procedures relating to correct site surgery, team time out, infection control and surgical item counts.

6.3 Hospital, State Based and National Safety Programs, Initiatives and Standards

Accredited Practitioners acknowledge the importance of ongoing safety and quality initiatives that may be instituted by the Hospital based upon its own safety and quality program, or safety and quality initiatives, programs or standards of State or Commonwealth health departments, statutory bodies or safety and quality organisations (including for example the national Australian Commission on Safety and Quality in Health Care or a State based independent statutory body such as the Health Quality & Complaints Commission in Queensland).

Accredited Practitioners will participate in and ensure compliance with these initiatives and programs (including if they are voluntary initiatives that the Hospital elects to participate in or undertake), whether these apply directly to the Accredited Practitioner or are imposed upon the Hospital and require assistance from the Accredited Practitioner to ensure compliance.

6.4 Treatment and financial consent

Accredited Practitioners must obtain 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 (including applicable legislation) 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 Accredited Practitioner and Patient or their legal guardian or substituted decision maker.

It is expected that informed consent will be obtained by the Accredited Practitioner under whom the Patient is admitted or treated, with this the sole legal responsibility of the Accredited Practitioner. 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, following which consent to the treatment will be obtained.

The consent process must also satisfy the Hospital's requirements from time to time as set out in its policy and procedures, including in relation to the documentation to be provided to the Hospital.

Accredited Practitioners must provide financial disclosure and obtain informed financial consent from their Patients in accordance with the relevant legislation, health fund agreements, policy and procedures of the Hospital.

6.5 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 satisfy the Hospital policy requirements, legislative requirements, State based standards, the content and standard required by the Australian Council on Healthcare Standards, accreditation requirements, and health fund obligations;

(c) they comply with all legal requirements and standards in relation to the prescription and administration of medication;

(d) Patient records maintained by the Hospital include all relevant information and documents reasonably necessary to allow Hospital staff and other Accredited Practitioners to care for Patients, including provision of pathology, radiology and other investigative reports in a timely manner;

(e) A procedure report is completed including a detailed account of the findings, technique undertaken, complications and post procedure orders;

(f) An anaesthetic report is completed, as well as documentation of the pre-anaesthetic evaluation, fully informed anaesthetic consent and post-anaesthetic evaluation;

(g) A discharge summary is completed that includes all relevant information reasonably required by the referring practitioner, general practitioner or other treating practitioner for ongoing care of the Patient.

6.6 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 ensure that all Pharmaceutical Benefits Scheme prescription requirements and financial certificates are completed in accordance with Hospital policy and regulatory requirements.

6.7 Quality improvement, risk management and regulatory agencies

(a) Accredited Practitioners are required to attend and participate in the Hospital's safety, quality, risk management, education and training activities, including clinical practice review and peer

review activities, and as required by relevant legislation, standards and guidelines (including those standards and guidelines set by relevant Commonwealth or State governments, health departments or statutory health organisations charged with monitoring and investigating safety and quality of health care).

(b) Accredited Practitioners will report to the Hospital incidents, complications, adverse events and complaints (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), complaints management, and open disclosure processes.

(c) 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.

(d) 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 a health complaints body, Coroner, Police, State Health Department and its agencies or departments, State Private Health Regulatory/Licensing Units, and Commonwealth Government and its agencies or departments.

6.8 Clinical speciality committees

The Chief Executive Officer may establish clinical speciality committees for the purpose of reviewing and advising the Chief Executive Officer on performance of the clinical speciality by reference to the Hospital's clinical services, Organisational Capability and Organisational Need. These committees may include but are not limited to peer review and quality activities.

Each clinical speciality committee, in consultation with the Chief Executive Officer, will establish terms of reference for the committee and will report annually, or as required by the Chief Executive Officer, on its activities to the Medical Advisory Committee, and make recommendations to the Medical Advisory Committee on issues relevant to the clinical speciality.

6.9 Participation in clinical teaching activities

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

6.10 Research

(a) The Hospital approves, in principle, the conduct of research (including a clinical trial) in the Hospital. However, no research will be undertaken without the prior approval of the Chief Executive Officer and Board, following written application by the Accredited Practitioner.

(b) The activities to be undertaken in the research must fall within the Scope of Practice of the Accredited Practitioner.

(c) For aspects of the research falling outside an indemnity from a third party (including the exceptions listed in the indemnity), the Accredited Practitioner must have in place adequate insurance with a reputable insurer to cover the medical research.

(d) Research shall be conducted in accordance with National Health and Medical Research Council requirements, National Statement on Ethical Conduct in Human Research 2007 (National Standard 5.1.2.4), and other applicable legislation. After appropriate advice, the Chief Executive Officer shall determine whether or not the research project needs to be

forwarded to an authorised Human Research Ethics Committee (HERC) for consideration. All research which carries more than a low risk must ne considered by a HREC.

(e) An Accredited Practitioner has no power to bind the Hospital to a research project (including a clinical trial) by executing a research agreement.

(f) There is no right of appeal from a decision to reject an application for research.

6.11 Obtain written approval for New Clinical Services

(a) Before treating patients with New Clinical Services, 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 and must fall within the licensed service capability of the Hospital.

(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 Chief Executive Officer's decision is final and there shall be no right of appeal from denial of requests for New Clinical Services.

6.12 Utilisation

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

Part C – Accreditation of Medical Practitioners

7. Credentialing and Scope of Practice

7.1 Eligibility for Accreditation as a Medical Practitioner

Accreditation as a Medical Practitioner will only be granted if the Medical Practitioner demonstrates adequate Credentials, is professionally Competent, satisfies the requirements of the By-laws, and is prepared to comply with the By-laws and the Hospital policies and procedures.

By the granting of Accreditation, the Medical Practitioner accepts compliance with the By-laws and the Hospital policies and procedures.

Any Medical Practitioner who falls outside of Accreditation requirements and therefore is not subject to a Credentialing process, before being permitted to attend the Hospital and be involved in clinical care of Patients, will be provided with and agree to 'terms of attendance' (however phrased) that will govern attendance at the Hospital, including appropriate supervision.

As a condition of Accreditation, Medical Practitioners are required to participate in regular peer review as required by their relevant College in order to satisfy College membership. In addition, Accredited Medical Practitioners must provide evidence of such peer review when requested by the Chief Executive Officer.

7.2 Entitlement to treat Patients at the Hospital

(a) Medical Practitioners who have received Accreditation pursuant to the By-laws are entitled to make a request for access to facilities for the treatment and care of their Patients within the

limits of the Accreditation Category, Accreditation Type and Scope of Practice attached to such Accreditation at the Hospital and to utilise services and equipment provided by the Hospital for that purpose, subject to the provisions of the By-laws, Hospital policies, resource limitations, and in accordance with Organisational Need and Organisational Capability.

(b) 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 Chief Executive Officer and the grant of Accreditation contains no conferral of, or a general expectation of, or a 'right of access'.

(c) A Medical Practitioner's use of the facilities for the treatment and care of Patients is limited to the Scope of Practice granted by the Chief Executive Officer and subject to the conditions upon which the Scope of Practice is granted, resource limitations, and Organisational Need and Organisational Capability. Accredited Practitioners acknowledge that admission or treatment of a particular Patient is subject always to bed availability, the availability or adequacy of nursing or allied health staff or facilities given the treatment or clinical care proposed.

7.3 Responsibility and basis for Accreditation and granting of Scope of Practice

The Chief Executive Officer will determine the outcome of applications for Accreditation as Medical Practitioners and defined Scope of Practice for each applicant. In making any determination, the Chief Executive Officer will make independent and informed decisions and in so doing will have regard to the matters set out in these By-laws and will have regard to the recommendations of the Medical Advisory Committee. The Chief Executive Officer may, at his/her discretion, consider other matters as relevant to the application when making his/her determination.

The following term of accreditation will apply for Accredited Practitioners:-

(a) Extraordinary Accreditation – Temporary Accreditation as provided in By-law 9.1 and Emergency Accreditation as provided in By-law 9.2

(b) Initial Accreditation – other than temporary or emergency Accreditation – is for a maximum of one year as provided in By-law 8.4 (a)

(c) Re-Accreditation – After Initial Accreditation is for a maximum of five years as provided in By-law 8.6

7.4 Principles of Credentialing and Accreditation

The following principles should be considered and guide those persons involved in making decisions in the Credentialing and Accreditation process:

(a) Credentialing and Accreditation are organisational governance responsibilities that are conducted with the primary objective of maintaining and improving the safety and quality of health care services.

(b) Processes of Credentialing and Accreditation are complemented by registration requirements and individual professional responsibilities that protect the community.

(c) Effective processes of Credentialing and Accreditation benefit patients, communities, health care organisations and health care professionals.

(d) Credentialing and Accreditation are essential components of a broader system of organisational management of relationships with health care professionals.

(e) Credentialing and Accreditation and any reviews should be a non-punitive process, with the objective of maintaining and improving the safety and quality of health care services.

(f) Processes for Credentialing and Accreditation depend for their effectiveness on strong partnerships between health care organisations and professional colleges, associations and societies.

(g) Processes of Credentialing and Accreditation should be fair and transparent, although recognising the ultimate ability of the Board and Chief Executive Officer to make decisions that they consider to be in the best interests of the organisation, its current and future patients.

7.5 Medical Advisory Committee

The Chief Executive Officer shall convene a Medical Advisory Committee and it will function in accordance with the terms of reference established for the Medical Advisory Committee and pursuant to any requirements set out in these By-laws.

The Medical Advisory Committee members, including the chairperson, will be Accredited Practitioners (or at least a majority of Accredited Practitioners) and will be appointed by the Board for such period as determined by the Board and may be removed from membership of the committee by the Board.

The Board may establish a Credentialing Committee, which will be a sub-committee of the Medical Advisory Committee. The Credentialing Committee will function in accordance with the terms of reference established for that committee. The primary role of a Credentialing Committee will be to conduct some aspects of the Credentialing requirements set out in these By-laws and make recommendations to the Medical Advisory Committee. In the event a Credentialing Committee is established, the responsibilities set out in these By-laws in relation to Credentialing will still ultimately remain with the Medical Advisory Committee.

In the absence of a Credentialing Committee, the role will be performed by the Medical Advisory Committee. In addition to the terms of reference established for the Medical Advisory Committee or Credentialing Committee, the Committees must be constituted according to and the members of the Committees must conduct themselves in accordance with any legislative obligations, including standards that have mandatory application to the Hospital and Committee members. For example, the obligations imposed pursuant to the *Private Health Facilities Act 1999* or standards set by the Health Quality & Complaints Commission (Qld).

The Chief Executive Officer and Director of Clinical Services will be entitled to attend meetings of the Medical Advisory Committee as ex-officio members, such that they will not have an entitlement to vote in relation to decisions or recommendations of the Medical Advisory Committee and Credentialing Committee. The only exception will be the Director of Clinical Services has an entitlement to vote on matters pertaining specifically to credentialing and clinical privileges in accordance with Standards contained in the *Private Health Facilities Act 1999.*

In making determinations about applications for Accreditation there will ordinarily be at least one member of the same speciality as the applicant on the Medical Advisory Committee, which may mean co-opting a committee member in order to assist with the determination. Where necessary, a member of the same specialty who is not accredited by the Hospital may be contacted for advice. It is, however, recognised that this may not always be possible or practicable in the circumstances, and a failure to do so will not invalidate the recommendation of the Medical Advisory Committee.

8. The process for appointment and re-appointment

8.1 Applications for Initial Accreditation and Re-Accreditation as Medical Practitioners

(a) 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 in writing on the prescribed form. All questions on the prescribed form must be fully completed and all required information and documents supplied before an application will be considered. Applications should be forwarded to the Chief Executive Officer at least six weeks prior to the Medical Practitioner seeking to commence at the Hospital or at least two months prior to expiration of the current Accreditation. Where this timeframe is unable to be achieved due to Organisational Need or patient needs, Temporary Accreditation or Emergency Accreditation will be considered at the discretion of the Chief Executive Officer.

(b) Applications will include a declaration signed by the Medical Practitioner to the effect that the information provided by the Medical Practitioner is true and correct, 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.

(c) The Chief Executive Officer or Medical Director may interview Medical Practitioners and/or request further information from applicants that the Chief Executive Officer considers appropriate.

(d) The Chief Executive 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 interview conducted, to the Medical Advisory Committee for consideration.

8.2 Consideration by the Medical Advisory Committee

(a) The Medical Advisory Committee will consider all applications for Accreditation and Re-Accreditation referred to it by the Chief Executive Officer.

(b) Consideration by the Medical Advisory Committee will include but not be limited to information relevant to Credentials, Competence, Current Fitness, Participation in Continuing Professional Development, Organisational Capability and Organisational Need.

(c) The Medical Advisory Committee will make recommendations to the Board of Governors as to whether the application should be approved and if so, on what terms, including the Accreditation Category, Accreditation Type and Scope of Practice to be granted.

(d) The Medical Advisory Committee will act and make recommendations in accordance with its terms of reference and any relevant policy, as amended from time to time, including in relation to the consideration of applications for Accreditation and Re-Accreditation.

(e) 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 the Chief Executive Officer to:

(i) initiate an Internal Review;

(ii) initiate an External Review;

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

(iv) apply conditions or limitations to Scope of Practice requested; and/or

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

(f) If the Medical Practitioner's Credentials and assessed Competence and performance do not meet the Threshold Credentials (if any) established for the requested Scope of Practice, the Medical Advisory Committee may recommend refusal of the application.

8.3 Consideration of applications for Initial Accreditation by the Chief Executive Officer

(a) In considering applications, the Chief Executive Officer will give due consideration to any other information relevant to the application as determined by the Chief Executive Officer, but the final decision is that of the Board of Governors and the Board of Governors is not bound by the recommendation of the Medical Advisory Committee. In addition to considering the recommendations of the Medical Advisory Committee, including Organisational Capability and Organisational Need, the Board of Governors may consider any matter assessed as relevant to making the determination in the circumstances of a particular case.

(b) The Board of Governors may defer consideration of an application in order to obtain further information from the Medical Advisory Committee, the Medical Practitioner or any other person or organisation.

(c) If the Board of Governors requires further information from the Medical Practitioner before making a determination, they will forward a letter to the Medical Practitioner:

(i) informing the Medical Practitioner that the Board of Governors requires further information from the Medical Practitioner before deciding the application;

(ii) identifying the information required. This may include, but is not limited to, information from third parties such as other hospitals relating to current or past Accreditation, Scope of Practice and other issues relating to or impacting upon the Accreditation with that other hospital; and

(iii) requesting that the Medical Practitioner provide the information in writing or consent to contacting a third party for information or documents, together with any further information the Medical Practitioner considers relevant within fourteen (14) days from the date of receipt of the letter.

(d) In the event that the information or documents requested by the Board of Governors is not supplied in the time set out in the letter, the Board of Governors may, at their discretion, reject the application or proceed to consider the application without such additional information.

(e) The Chief Executive Officer 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 Accreditation Category, Accreditation Type and Scope of Practice granted.

(f) The Chief Executive Officer will ensure that information relating to Accreditation Category, Accreditation Type and Scope of Practice is accessible to those providing clinical services within the Hospital.

(g) There is no right of appeal from a decision to reject an application for initial Accreditation, or any terms or conditions that may be attached to approval of an application for initial Accreditation.

8.4 Initial Accreditation tenure

(a) Initial Accreditation as a Medical Practitioner at the Hospital will be for an initial period of <u>one year.</u>

(b) Prior to the end of the initial 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. The Chief Executive Officer will seek assistance with the review from the relevant Medical Advisory Committee or Speciality Committee where established. The Chief Executive Officer may also initiate the review at any time during the initial 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.

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

(i) a review conducted by the Chief Executive Officer at the end of the initial period, or

(ii) a review conducted by the Chief Executive Officer at any time during the initial period, causes the Chief Executive Officer to consider:

(iii) the Medical Practitioner's Scope of Practice should be amended for any subsequent Accreditation granted, or

(iv) the initial period should be terminated, or

(v) the initial period should be extended, or

(vi) the Medical Practitioner should not be offered further Accreditation, the Medical Practitioner will be:

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

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

(d) Should the initial review outcome, including information obtained in paragraph (c) above, be unacceptable or insufficient to the Chief Executive Officer, they may:

(i) amend the Scope of Practice that will granted for any subsequent Accreditation; or

(ii) reject the continuation of Accreditation.

(e) Should the Medical Practitioner have an acceptable initial review outcome, the Medical Advisory Committee may recommend an additional Accreditation period of up to five 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.

(f) The Board of Governors will make the final determination on Accreditation for all Medical Practitioners at the end of the initial period. There will be no right of appeal at the end of the initial period for a determination that Accreditation will not be granted following conclusion of the initial period, or to any terms or conditions that may be attached to the grant of any Accreditation following the initial period. All Medical Practitioners shall agree with this as a condition of initial Accreditation.

8.5 Re-Accreditation

(a) The Chief Executive Officer will, at least two months prior to the expiration of any term of Accreditation of each Medical Practitioner (other than a initial period), provide to that Medical Practitioner an application form to be used in applying for Re-Accreditation.

(b) Any Medical Practitioner wishing to be Re-Accredited must send the completed application form to the Chief Executive Officer at least one month prior to the expiration date of the Medical Practitioner's current term of Accreditation.

(c) The Chief Executive Officer and Medical Advisory Committee will deal with applications for Re-Accreditation in the same manner in which they are required to deal with applications for initial Accreditation as Medical Practitioners.

(d) The rights of appeal conferred upon Medical Practitioners who apply for Re-Accreditation as Medical Practitioners (excepting applications for Accreditation after the initial period) are set out in these By-Laws.

8.6 Re-Accreditation tenure

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

8.7 Nature of appointment

(a) Accreditation does not of itself constitute an employment contract nor does it establish of itself a contractual relationship between the Medical Practitioner and the Hospital.

(b) Accreditation is personal and cannot be transferred to, or exercised by, any other person.

9. Extraordinary Accreditation

9.1 Temporary Accreditation

(a) The Chief Executive Officer 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 may consider Emergency Accreditation for short notice requests.

(b) Applications for Temporary Accreditation as Medical Practitioners must be made in writing on the prescribed form as for initial applications for Accreditation. All questions on the prescribed 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 failure to comply with Temporary Accreditation requirements.

(d) Temporary Accreditation will automatically cease upon a determination by the Chief Executive Officer of the Medical Practitioner's application for Accreditation or at such other time 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 four (4) months.

(f) There can be no expectation that a grant of Temporary Accreditation will mean that there is be a subsequent granting of Accreditation.

(g) The Medical Advisory Committee and Board of Governors will be informed of all Temporary Accreditation granted.

(h) There will be no right of appeal from decisions relating to the granting of Temporary Accreditation or termination of Temporary Accreditation.

9.2 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 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:

(i) verification of identity through inspection of relevant documents (eg driver's licence with photograph);

(ii) contact as soon as practicable 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 as soon as practicable;

(iv) confirmation of at least one professional referee of the Medical Practitioner's Competence and good standing;

(v) verification will be undertaken by the Chief Executive Officer and will be fully documented.

(c) Emergency Accreditation will be followed as soon as practicable with Temporary Accreditation or initial Accreditation processes, if required.

(d) 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.

(e) The Medical Advisory Committee and Board of Governors will be informed of all Emergency Accreditation granted.

(f) There will be no right of appeal from decisions on granting, or termination, of Emergency Accreditation.

9.3 Locum Tenens

Locums must be approved by the Chief Executive Officer before they are permitted to arrange the admission of and/or to treat Patients on behalf of Medical Practitioners.

Temporary Accreditation requirements must be met before approval of locums is granted.

There will be no right of appeal from decisions in relation to locum appointments.

10. Variation of Accreditation or Scope of Practice

10.1 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 Request for Amendment of Accreditation or Scope of Practice Form and provide relevant documentation and references in support of the amendment or variation.

(c) The process to adopt in consideration of the application for amendment or variation will be as set out in By-Laws 8.1 to 8.3.

(d) 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 in relation to Temporary Accreditation, Emergency Accreditation, or a locum tenens.

11. Review of Accreditation or Scope of Practice

11.1 Chief Executive Officer may initiate review of Accreditation or Scope of Practice

(a) The Chief Executive Officer may at any time initiate a review of any Accredited Practitioner's Accreditation or Scope of Practice where concerns or an allegation are raised about any of the following:

(i) Patient health or safety could potentially be compromised;

(ii) the rights or interests of a Patient, staff or someone engaged in or at the Hospital has been adversely affected or could be infringed upon;

(iii) the Medical Practitioner's level of Competence;

(iv) the Medical Practitioner's Current Fitness;

(v) the Medical Practitioner's Performance;

(vi) compatibility with Organisational Capability or Organisational Need;

(vii) the current Scope of Practice granted does not support the care or treatment sought to be undertaken by the Medical Practitioner;

(viii) confidence held in the Medical Practitioner;

(ix) compliance with these By-laws, including terms and conditions, or a possible ground for suspension or termination of Accreditation may have occurred;

(x) the efficient operation of the Hospital could be threatened or disrupted, the potential loss of the Hospital's licence or accreditation, or the potential to bring the Hospital into disrepute;

(xi) a breach of a legislative or legal obligation of the Hospital or imposed upon the Accredited Practitioner may have occurred; or

(xii) as elsewhere defined in these By-laws.

(b) A review may be requested by any other person or organisation, including external to the Hospital, however the commencement of a review remains within the sole discretion of the Chief Executive Officer or as directed by the Board.

(c) The Chief Executive Officer will determine whether the process to be adopted is an;

(i) Internal Review; or

(ii) External Review.

(d) Prior to determining whether an Internal Review or External Review will be conducted, the Chief Executive Officer may in his or her 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 Chief Executive Officer makes a determination whether a review will proceed, and if so, the type of review.

(e) The review may have wider terms of reference then a review of the Medical Practitioner's Accreditation or Scope of Practice.

(f) 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.

(g) 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 elect to notify if the Chief Executive Officer considers 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.

11.2 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 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 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 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 these 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 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 following 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 elect to notify if the Chief Executive Officer considers 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.

11.3 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 his/her 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 Chief Executive Officer 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 Chief Executive Officer 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 following 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 elect to notify if the Chief Executive Officer considers 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.

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

12.1 Suspension of Accreditation

(a) The Chief Executive Officer may immediately suspend a Medical Practitioner's Accreditation should the Chief Executive Officer believe, or have a sufficient concern:

(i) it is in the interests of Patient care or safety. This can be based upon an investigation by an external agency including a registration board, disciplinary body, Coroner or health complaints body, and may be related to a patient or patients at another Hospital not operated by the Hospital;

(ii) the continuance of the current Scope of Practice raises a significant concern about the safety and quality of health care to be provided by the Medical Practitioner;

(iii) it is in the interests of staff welfare or safety;

(iv) serious and unresolved allegations have been made in relation to the Medical Practitioner. This may be related to a patient or patients of another Hospital not operated by the Hospital, including if these are the subject of review by an external agency including a registration board, disciplinary body, Coroner or a health complaints body;

(v) the Medical Practitioner fails to observe the terms and conditions of his/her Accreditation;

(vi) the behaviour or conduct is in breach of a direction or an undertaking, or the Hospital By-Laws, policies and procedures;

(vii) the behaviour or conduct is such that it is unduly hindering the efficient operation of the Hospital at any time, or is bringing the Hospital into disrepute;

(viii) the behaviour or conduct is considered disruptive or a Behavioural Sentinel Event;

(ix) the behaviour or conduct of the Medical Practitioner is inconsistent with the values of the Hospital;

(x) the Medical Practitioner has been suspended by their registration board;

(xi) there is a finding of professional misconduct, unprofessional conduct, unsatisfactory professional conduct or some other adverse professional finding (however described) by a registration board or other relevant disciplinary body or professional standards organisation for the Medical Practitioner;

(xii) the Medical Practitioner's professional registration is amended, or conditions imposed, or undertakings agreed, irrespective of whether this relates to a current or former Patient of the Hospital;

(xiii) the Medical Practitioner has made a false declaration or provided false or inaccurate information to the Hospital, either through omission of important information or inclusion of false or inaccurate information;

(xiv) the Medical Practitioner fails to make the required notifications required to be given pursuant to these By-laws or based upon the information contained in a notification suspension is considered appropriate;

(xv) the Accreditation, clinical privileges or Scope of Practice of the Medical Practitioner has been suspended, terminated, restricted or made conditional by another health care organisation;

(xvi) the Medical Practitioner is the subject of a criminal investigation about a serious matter (for example a drug related matter, or an allegation of a crime against a person such as a sex or violence offence) which, if established, could affect his or her ability to exercise his or her Scope of Practice safely and competently and with the confidence of the Hospital and the broader community;

(xvii) the Medical Practitioner has been convicted of a crime which could affect his or her ability to exercise his or her Scope of Practice safely and competently and with the confidence of the Hospital and the broader community;

(xviii) based upon a finalised Internal Review or External Review pursuant to these By-laws any of the above criteria for suspension are considered to apply;

(xix) an Internal Review or External Review has been initiated pursuant to these By-laws and the Chief Executive Officer considers that an interim suspension is appropriate pending the outcome of the review; or

(xx) there are other unresolved issues or other concerns in respect of the Medical Practitioner that is considered to be a ground for suspension.

(b) The Chief Executive Officer shall notify the Medical Practitioner of:

(i) the fact of the suspension;

(ii) the period of suspension;

(iii) the reasons for the suspension;

(iv) if the Chief Executive Officer considers it applicable and appropriate in the circumstances, invite a written response from the Medical Practitioner, including a response why the Medical Practitioner may consider the suspension should be lifted;

(v) if Chief Executive Officer considers it applicable and appropriate in the circumstances, any actions that must be performed for the suspension to be lifted and the period within which those actions must be completed; and

(vi) the right of appeal, the appeal process and the time frame for an appeal.

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

(d) Ordinarily suspension will be suspension of Accreditation in its entirety, however the Chief Executive Officer may determine for a particular case that the suspension will be a specified part of the Scope of Practice previously granted and these By-laws in relation to suspension will apply to the specified part of the Scope of Practice that is suspended.

(e) The suspension is ended either by terminating the Accreditation or lifting the suspension. This will occur by written notification by the Chief Executive Officer.

(f) The affected Medical Practitioner shall have the rights of appeal established by these By-laws.

(g) The Chief Executive Officer will notify the Board of Governors and Medical Advisory Committee of any suspension of Accreditation.

(h) 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 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.

12.2 Termination of Accreditation

(a) Accreditation shall be immediately terminated by the Chief Executive Officer if the following has occurred, or if it appears based upon the information available to the 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 Adequate Professional Indemnity Insurance covering the Scope of Practice;

(iii) a term or condition that attaches to an approval of Accreditation is breached, not satisfied, or according to that term or condition results in the Accreditation concluding; or

(iv) a contract of employment or to provide services is terminated or ends, and is not renewed.

(b) Accreditation may be terminated by the Chief Executive Officer, if the following has occurred, or if it appears based upon the information available to the Chief Executive Officer the following has occurred:

(i) based upon any of the matters in By-Law 12.1(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 Chief Executive Officer does not have confidence in the continued appointment of the Medical Practitioner;

(iii) the Medical Practitioner is not regarded by the Chief Executive Officer as having the appropriate Current Fitness to retain Accreditation or the Scope of Practice, or the 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 consider that it has the capacity to accommodate 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 Chief Executive Officer;

(vi) the Scope of Practice is no longer supported by Organisational Capability or Organisational Need;

(vii) 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

(viii) 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 Chief Executive Officer shall notify the Medical Practitioner of:

(i) the fact of the termination;

(ii) the reasons for the termination;

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

(f) All terminations must be notified to the Board of Governors and Medical Advisory Committee.

(g) For a termination of Accreditation pursuant to By-law 12.2(a), there shall be no right of appeal.

(h) For a termination of Accreditation pursuant to By-law 12.2(b), the Medical Practitioner shall have the rights of appeal established by these By-laws.

(i) Unless it is determined not appropriate in the particular circumstances, the fact and details of the termination will be notified by the Chief Executive Officer to the Medical Practitioner's registration board and/or other relevant regulatory agency.

12.3 Imposition of conditions

(a) At the conclusion of or pending finalisation of an Internal or External Review, or in lieu of a suspension, or in lieu of a termination, the Chief Executive Officer may elect to impose conditions on the Accreditation or Scope of Practice.

(b) The 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, advise of the right of appeal, the appeal process and the timeframe for an appeal.

(c) If the 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.

(d) If the conditions are breached, then suspension or termination of Accreditation may occur, as determined by the Chief Executive Officer.

(e) The affected Medical Practitioner shall have the rights of appeal established by these By-laws.

(f) 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 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.

12.4 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 to cease 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 Chief Executive Officer to be insufficient, the Chief Executive Officer will raise these matters in writing with the Accredited Practitioner and invite a meeting to discuss. Following the meeting 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.

13. Appeal rights and procedure

13.1 Rights of appeal against decisions affecting Accreditation

(a) There shall be no right of appeal against a decision to not approve initial Accreditation, Temporary Accreditation, Emergency Accreditation, a locum appointment, or continued Accreditation at the end of a initial period or Temporary Accreditation, Emergency Accreditation or locum period.

(b) Subject to paragraph a) above, a Medical Practitioner shall have the rights of appeal as set out in these By-Laws.

13.2 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 Chief Executive Officer 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) Upon receipt of an appeal notice the Chief Executive Officer will immediately forward the appeal request to the chairperson of the Board of Governors.

(e) The chairperson of 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.

(f) The Appeal Committee shall comprise at least three (3) persons and will include:

(i) a nominee of the chairperson 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 Chief Executive Officer, who may be an Accredited Practitioner, and who must be independent of the decision under appeal regarding the Medical Practitioner;

(iii) any other member or members who bring specific expertise to the decision under appeal, as determined by the chairperson of the Board, who must be independent of the decision under appeal regarding the Medical Practitioner, and who may be an Accredited Practitioner. The chairperson of the Board in their complete discretion may invite the appellant to make suggestions or comments on the proposed additional members of the Appeal Committee (other than the nominees in (i) and (ii) above), but is not bound to follow the suggestions or comments.

(g) 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 chairperson of the Board will notify the appellant of the members of the Appeal Committee.

(h) 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 of the Appeal Committee may provide the appellant with copies of material to be relied upon by the Appeal Committee.

(i) 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.

(j) 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.

(k) The Chief Executive Officer (or nominee) may present to the Appeals Committee in order to support the decision under appeal.

(l) 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.

(m) The appellant shall not be present during Appeal Committee deliberations except when invited to be heard in respect of his/her appeal.

(n) 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.

(o) The Appeal Committee will make a written recommendation regarding the appeal to the chairperson of 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 of the Appeal Committee has the deciding vote. A copy of the recommendation will be provided to the appellant.

(p) The Board will consider the recommendation of the Appeal Committee and make a decision about the appeal.

(q) The decision of the Board will be notified in writing to the appellant.

(r) The decision of the Board is final and binding, and there is no further appeal allowed under these By-Laws from this decision.

(s) If a notification has already been given to an external agency, such as a registration Board, then the Board will notify that external agency of the appeal decision. If a notification has not already been given, the Board 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 D – Accreditation of Dentists

14. Accreditation and Scope of Practice of Dentists

By-laws 7 to 13 are hereby repeated in full substituting where applicable Dentist for Medical Practitioner.

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

Part E– Accreditation of Visiting Allied Health Professionals

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

By-laws 7 to 13 are hereby repeated in full substituting where applicable Allied Health Professional for Medical Practitioner.

This By-law 15 may also be utilised for other health practitioners who do not fall into the category of Medical Practitioner, Dentist or Allied Health Professional, with the process as modified by the Chief Executive Officer to suit the particular circumstances of the case.

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

Part F – Amending By-laws, annexures, and associated policies and procedures, and other matters

16. 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 Practitioners 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.

(c) The Board may approve any annexures that accompany these By-Laws, and amendments that may be made from time to time to those annexures, and the annexures once approved by the Board are integrated with and form part of the By-Laws. The documents contained in the annexures must be utilised and are intended to create consistency in the application of the processes for Accreditation and granting of Scope of Practice.

(d) The Board may approve forms, 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. These may include but are not limited to Accreditation and Scope of Practice requirements and the further criteria and requirements will be incorporated as criteria and requirements of these By-laws.

17. Audit and Compliance

The Chief Executive Officer will establish a regular audit process, at intervals determined to be appropriate by the Chief Executive Officer or as may be required by a regulatory authority, to ensure compliance with the processes set out in these By-Laws relating to Credentialing and Accreditation, and any associated policies and procedures.

The audit process will include identification of opportunities for quality improvement in the Credentialing and Accreditation processes that will be reported to the Board by the Chief Executive Officer.