MERCY HEALTH AND AGED CARE CENTRAL QUEENSLAND LIMITED

(ACN 096 724 033)

Mercy Health and Aged Care
Central Queensland Limited

By-Laws

Medical Practitioners, Dentists and Allied Health Professionals

Mater Misericordiae Hospitals
Mackay, Rockhampton, Gladstone and Bundaberg

Revision Date: *Approved at Board Meeting May 2019*



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PART A - INTERPRETATION AND GENERAL PROVISIONS

1. FORWARD

Mercy Health and Aged Care Central Queensland Limited (the Operator) is a not-for-profit Catholic organisation committed to delivering high quality, compassionate health and aged care services to the communities we serve. The Operator is a ministry of Mercy Partners. Mercy Partners is both Canonical Sponsor and Company Member of the Operator.

Responsibility for the governance of the Operator is vested in the Board of Directors with only a small number of powers reserved to Mercy Partners as the Company Member and Canonical Sponsor. Apart from these limited number of powers reserved to Mercy Partners, the Operator's Board of Directors exercise all governance decision making responsibilities and employs executive staff to manage its Heath and Aged Care Ministry.

The Operator employs some 1400 dedicated professional staff who work in a team environment delivering relevant, compassionate, innovative and responsive care.

These By-Laws apply to the Operator's hospitals located at Rockhampton, Gladstone, Mackay, and Bundaberg.

Accreditation, Credentialing and Scope of Clinical Practice are key elements of the Operator's clinical governance system in order to achieve the organisational objective of maintaining the quality of health services and safety of Patients. This includes implementation of processes so that Medical Practitioners and other categories of approved practitioner who are suitably experienced, trained and qualified to practice in a competent and ethical manner will practice within the Facilities of the Operator.

Safety and quality of health care for Patients involves a mutual commitment from the Operator, its staff and Accredited Practitioners. It is the expectation of the Operator that all involved in the care of Patients work towards this mutual commitment.

In making decisions with respect to these By-Laws and taking actions pursuant to these By-Laws, the safety and quality of health care for Patients, and consistency with the Vision, Philosophy, Mission & Ethics of the Operator and Mercy Partners, will be the paramount considerations.

In accordance with a process of continuous improvement, these By-Laws and the processes of Accreditation, Credentialing and Scope of Clinical Practice will be subject to audit, review and validation on a regular basis. The aim will be to ensure that the processes and outcomes remain diligent and effective and the objectives set out above continue to be achieved in the most effective manner.

2. VISION, PHILOSOPHY, MISSION & ETHICS

The Board of Directors has articulated Mission and Vision Statements for the Operator and it is important to the Board that the application of the By-Laws is consistent with the Vision, Philosophy, Mission & Ethics of the Operator and Mercy Partners.

Vision Statement

"Caring for you for life" - Providing excellence of care for those we serve.

Philosophy Statement

At Mercy Health and Aged Care Central Queensland Limited, deep trust in the mercy and compassion of God is the foundation of our Catholic philosophy.

- Catherine McAuley's legacy of care and service for all in need is the inspiration for our work.
- We believe in, and witness to, the dignity of the human person and the value and quality of human life at all stages of its existence.
- We believe in excellence in the provision of care wherever the need arises.
- We believe in upholding the teachings of the gospel and the Catholic Church on the crucial health and welfare issues of our time.
- We believe in providing our services with excellence, justice, compassion, integrity and respect for each individual regardless of race, gender, creed or socio-economic status.

Mission Statement

To continue the healing ministry of Jesus Christ by providing a high standard of holistic health care consistent with community need.

Ethics

As a Catholic health care provider, Mercy Health & Aged Care Central Queensland Limited follows a code of ethics as outlined in the Code of Ethical Standards for Catholic Health and Aged Care Services in Australia.

3. PURPOSE OF THIS DOCUMENT AND UNDERSTANDING OF BY-LAWS

(a) The By-Laws provide direction to the Board and Chief Executive Officer to exercise certain aspects of their respective governance and managerial responsibility.

(b) Patient care is provided by Accredited Practitioners who have been granted access to use the Facilities where they have been Accredited in order to provide that care.

(c) The By-Laws define the relationship and obligations between a Facility and its Accredited Practitioners.

(d) The By-Laws set out certain terms and conditions upon which an applicant may apply to be Accredited, the basis upon which an Accredited Practitioner may admit Patients and/or care and treat Patients at a Facility, and the terms and conditions for continued Accreditation.

(e) This document sets out the entirety of the processes and procedures available to Accredited Practitioners with respect to all matters relating to and impacting upon Accreditation.

(f) Each Facility 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.

(g) 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.

(h) These By-Laws will take effect and supersede any previous published version. These By-Laws will be operational and effective regardless of when an issue or circumstance arises or if an issue or circumstance has been previously subject to contemplation of previous By-Laws.

4. DEFINITIONS

In these By-Laws, words or expressions which are capitalised have the following meanings:

"**ACCREDITATION**" means the authorisation in writing by the Board for a Practitioner to treat Patients at a Facility within a designated Scope of Clinical Practice and in accordance with the conditions specified in that authorisation, and the process described in these By-Laws leading to that authorisation. For the purpose of these By- Laws, a Practitioner is deemed *"to treat Patients"* if that Practitioner is required to chaperone and/or supervise another Practitioner who is treating Patients at a Facility. In those circumstances, the chaperoning or supervising Practitioner must obtain Accreditation.

"**ACCREDITED PRACTITIONER**" means a Practitioner authorised to treat Patients at a Facility within a designated Scope of Clinical Practice and in accordance with any specified conditions.

"ADEQUATE PROFESSIONAL INDEMNITY INSURANCE" means insurance to cover all potential liability of the Accredited Practitioner and any employees or agents of the Accredited Practitioner, for all potential liability arising during the period of Accreditation (even if a claim were to be made following the conclusion of Accreditation), that is with a reputable insurance company acceptable to the Operator, in an amount and on terms that the Operator considers in its absolute discretion to be sufficient. The insurance must be adequate for Scope of Clinical Practice and level of activity. Umbrella professional indemnity insurance available as part of membership of a union or other representative organization, will not be regarded as Adequate Professional Indemnity Insurance.

"**ALLIED HEALTH PROFESSIONAL**" means a person registered under the applicable legislation to practise as an allied health professional in the State of Queensland or in Australia, as the case may be and includes, but are not limited to audiologists, chiropractors, clinical psychologists, dieticians, health counsellors, occupational therapists, optometrists, pharmacists, physiotherapists, podiatrists, radiographers, social workers, speech pathologists, and other professionals approved by the Board.

"**APPLICATION FORM**" means the applicable application form approved by the Operator from time to time for use by a Practitioner to apply for Accreditation or Re-Accreditation at any Facility.

"AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY (AHPRA)" means the organisation responsible for the registration and accreditation of health professions across Australia.

"BEHAVIOURAL STANDARDS" means the standards of behavior expected of Accredited Practitioners arising from personal interactions and communication with other Accredited Practitioners, employees of the Operator, the Board, executive of the Operator, third party providers of services, Patients, family members of Patients and others. The minimum standard required of Accredited Practitioners in order to achieve the Behavioural Standards is compliance with the Code of Conduct, any other Facility policy or directive that sets out expectations of professional conduct and behavioural standards, adherence to the expectations set out in the *Good Medical Practice: A Code of Conduct for Doctors in Australia*, acting consistently with the Vision, Philosophy, Mission & Ethics of the Operator and compliance with any specific written directions or undertakings.

"**BOARD**" means the Board of Directors of the Operator.

"**BY-LAWS**" means these By-Laws.

"**CHAIRMAN OF THE BOARD**" means the person appointed to that position or acting in that position at any relevant time.

"**CHIEF EXECUTIVE OFFICER**" or "**CEO**" means the senior management officer for the Operator.

"**CLINICAL DEPARTMENT**" means a department or section of Accredited Practitioners in like sub-specialties, the establishment of which has been approved by the Chief Executive Officer or Board.

"CLINICAL REVIEW COMMITTEE" means the formal process used to provide a clinician driven monitoring and evaluation process for the inpatient continuum of care. This Committee oversees the clinical practice activities within a Facility ensuring a high standard of quality patient care is maintained.

"**CODE OF CONDUCT**" meets the Code of Conduct of the Operator, Reference number MH&ACCQL-HRM-P 5.02, as amended or replaced.

"CODE OF ETHICS OF THE AUSTRALIAN MEDICAL ASSOCIATION" means the Australian Medical Association (AMA) Code of Ethics (2004), as amended or replaced.

"**CODE OF ETHICAL STANDARDS**" means the Code of Ethical Standards for Catholic Health and Aged Care Services in Australia (2001), as amended or replaced.

"**CONSULTANT**" means a Medical Practitioner not Accredited at a Facility who is sought to provide a consultation at that Facility as set out in By-Law 18.

"**CONSULTANT ACCREDITATION**" means Accreditation of a Consultant in accordance with By-Law 18.

"**CORONER**" means the coroner as that term is defined in the *Coroners Act 2003* (Qld).

"CRAFT GROUP" means a specialty medical group of Accredited Practitioners who provide oversight of clinical governance for the specialty area in line with best practice, legislative requirements, organisational policy to ensure safe and high quality provision of care for Patients.

"**CREDENTIALING**" means the formal process used to verify the Credentials of a Practitioner for the purpose of forming a view as to their competence, performance and professional suitability to provide safe, high quality health care services.

"**CREDENTIALING COMMITTEE**" means a committee established in accordance with By-Law 10(c) composed in accordance with By-Law 35 and with the role set out in By-Law 36.

"**CREDENTIALS**" means the identity, education, formal qualifications, equivalency of overseas qualifications, post-graduate degrees/awards/fellowships/certificates, professional training, continuing professional development, professional experience, recency of practice, maintenance of clinical competence, and other skills/attributes (for example in leadership, research, education, communication, teamwork), that contribute to the person's competence, performance, Current Fitness and professional suitability to provide safe, high quality health care services. For the purposes of these By-Laws, a Practitioner's history of and current status with respect to professional registration, disciplinary actions, By-Law actions, clinical outcomes, compensation claims, complaints and concerns – clinical and behavioural, professional indemnity insurance, criminal record and compliance with the Code of Conduct and the Code of Ethical Standards are also regarded as relevant to their Credentials.

"**CURRENT FITNESS**" is the current fitness required of a Practitioner to carry out the Scope of Clinical Practice sought or currently authorised. 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 which detrimentally affects or is likely to detrimentally affect the person's physical or mental capacity to practise their profession and carry out the Scope of Clinical Practice sought or authorised in a safe manner. Habitual drunkenness or addiction to deleterious drugs is considered to be a physical or mental disorder which would prevent the person from having satisfactory Current Fitness.

"**DENTIST**" has the same meaning as a health practitioner in the dental profession as defined in the National Law.

"**DIRECTOR OF NURSING**" however termed means the person appointed by the Chief Executive Officer/Board to the senior nursing administration position at any Facility of the Operator and, in the absence of that person, the person appointed to act in that position for the time being.

"DISRUPTIVE BEHAVIOUR" means behaviour that can reasonably be considered unprofessional, inappropriate, intimidating, disruptive, bullying, threatening, aggressive or violent manifested through personal interactions (including physical, written, verbal, online or by any other means).

"EGREGIOUS BEHAVIOUR" means behaviour that may be considered inappropriate, unprofessional, intimidating, disruptive, bullying, threatening, aggressive or violent manifesting through personal interactions (including physical, verbal or online) which may indicate serious concerns about an Accredited Practitioner's level of functioning or performance and suggests potential for adversely affecting Patient safety, Facility staff, or Facility outcomes. This may manifest as a single episode or through multiple disruptive behavioural episodes.

"**EMERGENCY ACCREDITATION**" means Accreditation of a Practitioner in an urgent or disaster situation in accordance with By-Law 19.

"EXECUTIVE DIRECTOR OF MEDICAL SERVICES" means the person appointed by the Chief Executive Officer / Board to the clinical governance of medical services for the Operator and, in the absence of that person, the person appointed to act in that position for the time being.

"**EXECUTIVE OFFICER**" means the person appointed by the Board as the senior executive in a Facility and, in the absence of that person, means the person appointed to act in that position for the time being.

"**FACILITY**" means each hospital of the Operator. For the purpose of clarity, each of the hospitals at Mackay, Rockhampton, Gladstone and Bundaberg is (individually) a Facility.

"**FACILITY'S NEEDS AND CAPABILITIES**" means the Facility's ability to provide the facilities, services and clinical and non-clinical services, procedures or other interventions. The Operator's capability will be determined by consideration of the availability, limitations and / or restrictions of the services, staffing, facilities, equipment, and support services required. The approved level of service capability may be specified on the Facility licence to operate.

"GOOD MEDICAL PRACTICE: A CODE OF CONDUCT FOR DOCTORS IN AUSTRALIA" means the Medical Board of Australia *Good Medical Practice: A Code of Conduct for Doctors in Australia* document which describes what is expected of all doctors registered to practise medicine in Australia.

"**INITIAL ACCREDITATION**" means the first time that a Practitioner receives Accreditation. It does not include Temporary Accreditation, Locum Accreditation, Consultant Accreditation or Emergency Accreditation.

"**LOCUM ACCREDITATION**" means Accreditation of a Practitioner as a locum tenens in accordance with By-Law 17.

"**MEDICAL ADVISORY COMMITTEE**" means a committee established in accordance with By-Law 10(a) composed in accordance with By-Law 31 and with the role set out in By-Law 32.

"**MEDICAL PRACTITIONER**" has the same meaning as a health practitioner in the medical profession as defined in the National Law.

"**NATIONAL LAW**" means the *Health Practitioner Regulation National Law Act 2009* (Qld).

"NATIONAL SAFETY & QUALITY HEALTH CARE STANDARDS (NSQHS)" means the Safety and Quality in Health Care Standards developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC).

"**NATIONAL STATEMENT**" means the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research* (2007), as amended or replaced.

"**NEW CLINICAL SERVICE, PROCEDURE OR OTHER INTERVENTION**" means a clinical service, procedure or intervention that is new to the relevant Facility, and requires more than incremental change in the way in which health care services are delivered at the Facility. It may have been established in other organisational settings and be deemed by a responsible body of medical opinion to be of benefit to Patients, or it may remain experimental, and therefore subject to review by a properly constituted human research ethics committee or clinical ethics committee (as appropriate).

"**OFFICE OF THE HEALTH OMBUDSMAN**" means the Office of the Health Ombudsman or OHO as that term is defined in the *Health Ombudsman Act 2013* (Qld).

"**OPERATOR**" means Mercy Health and Aged Care Central Queensland Limited (ACN 096 724 033), being the provider of health services at the Facilities.

"**PATIENT**" means a patient admitted to or treated by or at a Facility.

"**PRACTITIONER**" means, as the context requires:

(a) a Medical Practitioner, who is or may become a visiting Medical Practitioner at a Facility, or is or may become employed by the Operator;

(b) a Dentist, who is or may become a visiting Dentist at a Facility;

(c) an Allied Health Professional, who is or may become a visiting Allied Health Professional at a Facility; or

(d) any other category, approved by the Board, of professionals (including chaperoning and/or supervising Practitioners) who provide health services.

"**RE-ACCREDITATION**" means any Accreditation after the Initial Accreditation.

"**REGISTRATION BOARD**" means the applicable registration board, if any, for a Practitioner.

"**SCOPE OF CLINICAL PRACTICE**" means the extent of clinical practice which an Accredited Practitioner is authorised to undertake within a Facility based on the individual's Credentials, competence, performance and professional suitability, and the Facility's Needs and Capabilities. This is sometimes called "clinical privileges".

"SURGICAL ASSISTANT" means Medical Practitioner, Surgical Registrar (nil visitation rights) or Registered Nurse (employed by the Accredited Practitioner) who assists an Accredited Practitioner in the operating theatres of a Facility.

"**TEMPORARY ACCREDITATION**" means Accreditation of a Practitioner for temporary purposes in accordance with By-Law 17.

5. INTERPRETATION

In these By-Laws:

(a) headings are inserted for convenience only and do not affect the interpretation of these By-Laws;

(b) a reference in these By-Laws to any law, legislation or legislative provision includes any statutory modification, amendment or re-enactment, and any subordinate legislation or regulations issued under that legislation or legislative provision;

(c) a reference to a clause, By-Law, part, schedule or attachment is a reference to a clause, By-Law, part, schedule or attachment of or to these By-Laws;

(d) where a word or phrase is given a defined meaning, another part of speech or other grammatical form in respect of that word or phrase has a corresponding meaning;

(e) a word which denotes the singular also denotes the plural, a word which denotes the plural also denotes the singular, and a reference to any gender also denotes the other gender;

(f) a reference to the word "include" or "including" is to be construed without limitation;

(g) where there is use of the title chairman, the incumbent of that position for the time being may choose to use whichever designation that person so wishes; and

(h) any annexures form part of these By-Laws.

6. THE BOARD

The Board has the authority on behalf of the Operator to make By-Laws, rules and policies for the governance and effective operation of each Facility as it may deem necessary from time to time.

7. CHIEF EXECUTIVE OFFICER

The Chief Executive Officer is:

(a) the officer responsible for the conduct of the Operator;

(b) the spokesperson and, other than in exceptional circumstances, the channel for all formal communications to and from the Operator;

(c) responsible for the management of the Operator and its staff and resources including the provision of Patient care to acceptable standards, in accordance with the policies and directives of the Board; and

(d) responsible for ensuring compliance with all laws, these By-Laws and all other legal requirements of the Operator.

The Chief Executive Officer may delegate in writing certain responsibilities conferred by these By-Laws.

8. EXECUTIVE DIRECTOR OF MEDICAL SERVICES

The Executive Director of Medical Service is the Officer:

(a) to assist in providing communication to and from Medical Practitioners across the organisation.

(b) to support and advise the Operator and its staff in both the maintenance of clinical standards and the development of new medical practice across the organisation.

(c) to assist in advocating for optimal health service delivery relevant to community need in collaboration with health partners across the spectrum of the healthcare industry

(d) to support the Chief Executive Officer and Executive Officers in ensuring compliance with all laws, these By-Laws and all other legal requirements of the Operator.

9. EXECUTIVE OFFICER

The Executive Officer:

(a) is the officer at a Facility to whom all staff, through their respective managers, are responsible;

(b) is the spokesperson and, other than in exceptional circumstances, the channel for all formal communications to and from a Facility;

(c) is responsible for the management of the Facility and its staff and resources including the provision of Patient care to acceptable standards, in accordance with the policies and directives of the Board;

(d) may establish Clinical Departments of Accredited Practitioners at a Facility to facilitate achievement of a Facility's objectives; and

(e) is responsible for ensuring compliance with all laws, these By-Laws and all other legal requirements at a Facility.

10. FACILITY COMMITTEES

(a) The Executive Officer of each Facility must establish a committee covering medical advisory functions for that Facility. The membership of each such committee must be approved by the Chief Executive Officer. A medical advisory committee can cover one or more Facilities.

(b) The Board may establish any other committees that any Facility, in consultation with the Board, determines are necessary from time to time.

(c) The Board must establish one Credentialing Committee to advise the Operator and Chief Executive Officer in relation to all Facilities.

(d) All committees are to have a membership, chairman, secretary, terms of reference and meeting procedure.

(e) Any two or more Facilities may merge the committees, established under By-Law 10(a) across those Facilities, with the agreement of the Chief Executive Officer.

(f) Initially, Medical Advisory Committees will be convened for each of:

(i) the Mater Hospital Mackay;

(ii) the Mater Hospitals Rockhampton and Gladstone; and

(iii) the Mater Hospital Bundaberg.

PART B - ACCREDITATION OF PRACTITIONERS

11. ACCREDITATION OF PRACTITIONERS

(a) A Practitioner must not provide health services (including the chaperoning or supervision of another Practitioner) in a Facility without obtaining Accreditation.

(b) An Accredited Practitioner is permitted to treat Patients at a Facility but must only do so in accordance with the terms of their Scope of Clinical Practice and any specified conditions.

(c) These By-Laws do not deal with ways in which the Operator may employ or engage persons other than Practitioners to provide health services in a Facility.

(d) Accreditation will only be granted if the applicant demonstrates adequate Credentials, meets requirements of Facility's Needs and Capabilities, otherwise satisfies the requirements of the By-Laws, agrees to comply with and accept all terms, conditions and processes set out in the By-Laws, and provides written acknowledgment of such preparedness.

(e) The granting of Accreditation does not, of itself, constitute an employment contract nor does it establish a contractual relationship or any implied contractual terms between the Accredited Practitioner and the Facility or the Operator, nor does it confer any legally enforceable right, or create in any Accredited Practitioners any legitimate expectation, in relation to any matter or thing referred to in the By-Laws.

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

(g) It is a condition of accepting Accreditation, and of ongoing Accreditation, that the Accredited Practitioner understands and agrees that these By-Laws are the full extent of processes and procedures available to the Accredited Practitioner with respect to all matters relating to and impacting upon Accreditation and no additional procedural fairness or natural justice principles will be incorporated or implied, other than processes and procedures that have been explicitly set out in these By-Laws.

(h) Accredited Practitioners acknowledge and agree as a condition of the granting of, and ongoing Accreditation, that the granting of Accreditation establishes only that the Accredited Practitioner is a person able to provide services at the Facility. As well as the obligations and expectations with respect to the Accredited Practitioner while providing services for the period of Accreditation; the granting of Accreditation creates no rights or legitimate expectation with respect to access to the Facility or its resources. While representatives of the Operator will generally conduct themselves in accordance with these By-Laws, they are not legally bound to do so and there are no legal consequences for not doing so.

(i) Conferral of Accreditation provides the Accredited Practitioner with an ability on each occasion to make a request for access to facilities of the Facility where he or she maintains Accreditation for the treatment and care of a Patient, within the limits of the Accredited Practitioner's Scope of Clinical Practice, and to utilise facilities provided by the Facility for that purpose, subject always to the provisions of the By-Laws, Operator's policies, resource limitations, and in accordance with Facility's Needs and Capabilities at the time of the request for access.

(j) The decision to grant access to the Facility or particular resources for the treatment and care of a Patient is on each occasion within the sole discretion of the Executive Officer. The grant of Accreditation contains no general entitlement to or right of access to a Facility. The Executive Officer retains a right of refusal for a particular treatment, use of resources or care of Patient. The decision of the Executive Officer is final and there shall be no right of appeal from a decision made pursuant to this By-Law.

12. ADVANCED SCOPE OF CLINICAL PRACTICE

(a) Where an Accredited Practitioner's Scope of Clinical Practice is beyond that which is normally considered standard at the time of completion of a specialist fellowship or there has been more than 6 years since the completion of a general fellowship, they may be credentialed and approved for an advanced Scope of Clinical Practice to identify and confirm specific required additional training and experience in a specific area of clinical activity.

(b) Areas where Credentialing for an advanced Scope of Clinical Practice is to be undertaken will be determined by the Credentialing Committee and that Committee will be informed by the process of introduction of New Clinical Services, Procedures and Other Interventions and by current specialty college or society advice.

13. TERM OF ACCREDITATION OF ACCREDITED PRACTITIONERS

(a) Initial Accreditations will commence on the date stated in the written notice of Initial Accreditation provided to the Accredited Practitioner and will expire on 30 June immediately following the first anniversary of the date of commencement.

(b) If a Re-Accreditation application is approved pursuant to these By-Laws, unless otherwise specified the Re-Accreditation will be for a period of 3 years commencing on the day immediately following the expiry of the Accreditation or previous Re-Accreditation, as the case may be.

(c) If an application to vary the Scope of Clinical Practice is approved the applicant's new Scope of Clinical Practice will commence on the date stated in the written notice of variation and will expire on the day that the applicant's then current Accreditation or Re-Accreditation, as the case may be, expires.

(d) The term of Temporary Accreditation is as provided in By-Law 17(f) and 17(g).

(e) The term of Locum Accreditation is as provided in By-Law 17(f) and 17(g).

(f) The term of a Consultant Accreditation is the duration of a single consultation as authorised in By-Law 18(b).

(g) The term of Emergency Accreditation is as provided in By-Law 19(d)

14. APPLICATION FORM

The Executive Officer or delegate must provide each Practitioner seeking Accreditation or Re-Accreditation with access to an Application Form and a copy of these By-Laws.

It is expected that the By-Laws are read in their entirety by the Practitioner as part of the application process.

15. APPLICATION FOR ACCREDITATION

A Practitioner seeking Initial Accreditation to practise in a Facility must complete an Application Form and provide the form to the Executive Officer or delegate.

16. CONSIDERATION AND DETERMINATION OF APPLICATION

(a) Following receipt of a completed Application Form, the Executive Officer:

  (i) may interview the applicant and/or otherwise obtain information from the applicant, which the Executive Officer considers appropriate; and

  (ii) must ensure that the Application Form is complete and requests for further information complied with.

(iii) will review the minimum three (3) references. At least two references must be from persons with the same or related speciality as the applicant and at least one reference must be from a person who can verify, preferably for at least a 12 month period within the previous three years, the type and location of patients, clinical services, procedures or other interventions performed and diagnoses treated by the applicant. The references should provide evaluatory comments on the applicant's technical performance, communication skills and teamwork.

(iv) upon being satisfied with the completed application and references review, will refer the application and Executive Officer's observations to the Credentialing Committee for consideration by the Credentialing Committee.

(b) The procedure on receipt of a completed Application Form in By-Law 16(a) does not apply to any applicant who has had an Accreditation terminated or suspended on any previous occasion, whether at a Facility or any other health facility. In these circumstances, the Chief Executive Officer must consider this application separately and must, in his or her discretion, refer the application to the Credentialing Committee or make an appropriate recommendation directly to the Board. The Board must make a final determination as to any application of this kind.

(c) Subject to By-Law 16(d), the Credentialing Committee must:

(i) review the application (and may request further information from, or an interview with, the applicant), satisfy itself as to the applicant's Credentials, taking into account the current Scope of Clinical Practice (if any) and the Facility's Needs and Capabilities;

(ii) make recommendations as to the Practitioner's Accreditation and Scope of Clinical Practice; and

(iii) forward its recommendation to the Chief Executive Officer or delegate.

(d) All proceedings before the Credentialing Committee under By-Law 16(c) must be conducted informally and the rules of evidence will have no application.

(e) At any time during the Credentialing process, a request may be made for further information or documents from an applicant, a request for verification of information or documents submitted (for example if an original is not supplied this may require certification by a Justice of the Peace or similar certifying agent) or a request for permission to directly contact third parties, and any refusal or failure to respond to the request may result in rejection of the application.

The Chief Executive Officer or delegate must submit the Credentialing Committee's recommendation to the Board, together with any advice the Chief Executive Officer of delegate may have. The Board must make a final determination as to the application.

(f) Within 7 days of arriving at its decision, the Board's delegate must notify the applicant in writing of the decision.

(g) There is no right of appeal in relation to the Board's determination of an application for Initial Accreditation.

17. TEMPORARY OR LOCUM ACCREDITATION

(a) The Chief Executive Officer, Executive Officer or delegate of either may authorise Temporary or Locum Accreditation of a Practitioner, including an authorised Scope of Clinical Practice, after consultation with the chairman of the Credentialing Committee or another member of the Credentialing Committee if the chairman of the Credentialing Committee is unavailable, before an application for Initial Accreditation has been determined.

(b) The Executive Officer must be notified in writing of all proposed locum arrangements before those arrangements commence and will as soon as practicable after receipt of that notification, inform the relevant Accredited Practitioner for whom the locum has been engaged whether Locum Accreditation has been authorised.

(c) The authorisation of Temporary or Locum Accreditation will only be made when it is considered necessary by the Executive Officer to do so because of the time delay that may be experienced before the Credentialing Committee and the Board are able to consider an application for Initial Accreditation.

(d) A Practitioner seeking Temporary or Locum Accreditation must submit an Application Form to the Executive Officer or delegate, along with all required supporting documentation including curriculum vitae with education, training and employment history.

(e) At a minimum, Credentialing for Temporary or Locum Accreditation requires verification of identity through inspection of relevant documents (eg, a driver's licence with a photograph), verification as soon as possible with the Registration Board of the Practitioner's registration history, good standing and past record of professional sanctions or disciplinary actions, and confirmation as soon as practicable by at least one professional referee of the Practitioner's competence and good standing. Credentialing for Temporary or locum Accreditation may also include confirmation of claimed employment history or good standing through immediate contact with the Practitioner's most recent place of appointment.

(f) A Temporary or Locum Accreditation remains in force until the earlier of a final determination of the application for Initial Accreditation or a specified date or event or 3 months.

(g) The Executive Officer or delegate may extend the term of a Temporary or Locum Accreditation but only so that the total term is a maximum of 4 months.

(h) Temporary or Locum Accreditation may be terminated by the Executive Officer with the concurrence of the Chief Executive Officer and/or the Executive Director of Medical Services, upon the Executive Officer receiving notice of any failure by the Practitioner to comply with the By-Laws. There is no right of appeal in relation to a decision to terminate a Temporary or Locum Accreditation.

18. CONSULTANT ACCREDITATION

(a) Accredited Practitioners must notify the Executive Officer in writing in the event that a Consultant is called in for an opinion or any single consultation at a Facility, before the Consultant attends the Facility.

(b) The Executive Officer or delegate must authorise Accreditation of a Consultant, including an authorised Scope of Clinical Practice, after consultation with the chairman of the Credentialing Committee or another member of the Credentialing Committee if the Chairman of the Credentialing Committee is unavailable, before the Consultant may conduct a consultation at a Facility. The term of any consultancy must be advised to an Accredited Consultant.

(c) At a minimum, Credentialing for Accreditation of a Consultant requires verification of identity through inspection of relevant documents (eg, a driver's licence with a photograph), verification as soon as possible with the Registration Board of the Consultant's registration history, good standing and past record of professional sanctions or disciplinary actions, and confirmation as soon as practicable by at least one professional referee of the Consultant's competence and good standing. Credentialing for Accreditation of a Consultant may also include confirmation of claimed employment history or good standing through immediate contact with the Consultant's most recent place of appointment.

19. EMERGENCY ACCREDITATION

(a) Emergency Accreditation may be made in an urgent or disaster situation to ensure patient safety and care is not compromised in the absence of a normally available Accredited Practitioner's services.

(b) The Chief Executive Officer, Executive Officer or delegate may authorise Emergency Accreditation of a Practitioner including an authorised Scope of Clinical Practice.

(c) At a minimum, Credentialing for Emergency Accreditation requires verification of identity through inspection of relevant documents (eg, driver's licence with photograph), verification as soon as possible with the Registration Board of the Practitioner's registration history, good standing and past record of professional sanctions or disciplinary actions, and confirmation as soon as practicable by at least one professional referee of the Practitioner's competence and good standing. Credentialing for Emergency Accreditation may also include confirmation of claimed employment history or good standing through immediate contact with the Practitioner's most recent place of appointment.

(d) Emergency Accreditation is for 72 hours or until the next working day of the Operator's administration, to allow the applicant time to complete an Application Form to initiate the normal Accreditation process as soon as reasonably practicable.

(e) Where applicable, the Practitioner who provides emergency care must advise a Patient's own treating Practitioner at the earliest possible time of the emergency and the actions taken in regard to the Patient.

20. ACCREDITATION IN ANOTHER FACILITY

(a) Practitioners who hold Accreditation in one Facility (existing Facility) and who wish to apply for Accreditation in another Facility (further Facility) must apply in writing (without the need for formal application under By- Law 15) to the Executive Officer of the further Facility requesting Accreditation in the further Facility. The Practitioner must provide written permission for the Executive Officer of the further Facility to obtain all relevant information from the existing Facility.

(b) On receiving the application, the Executive Officer must obtain from the existing Facility a copy of all relevant information relating to the Accreditation and Scope of Clinical Practice at the existing Facility and must submit that information to the Credentialing Committee for consideration.

(c) Subject to By-Law 20(d), the Credentialing Committee must:

(i) review the application (and may request further information from, or an interview with, the applicant), satisfy itself as to the applicant's Credentials, taking into account the current Scope of Clinical Practice and the Facility's Needs and Capabilities;

(ii) make recommendations as to the Practitioner's Accreditation and Scope of Clinical Practice at the further Facility; and

(iii) forward its recommendation to the Chief Executive Officer or delegate.

(d) All proceedings before the Credentialing Committee under By-Law 20(c) must be conducted informally and the rules of evidence will have no application.

(e) The Chief Executive Officer or delegate must submit the Credentialing Committee's recommendation to the Board, together with any advice the Chief Executive Officer or delegate may have.

(f) The Board must make a final determination as to the application. There is no right of appeal in relation to the Board's determination.

(g) If approved, the term of the Accreditation at the further Facility will expire on the date of expiry of the term of the Accreditation of the existing Facility.

21. RE-ACCREDITATION, RE-CREDENTIALING AND RE-DEFINING SCOPE OF CLINICAL PRACTICE

(a) The Executive Officer will, at least three months before the expiry of any term of an Initial Accreditation or Re-Accreditation (as the case may be) of each Accredited Practitioner, provide that Accredited Practitioner with an Application Form.

(b) Any Accredited Practitioner wishing to apply for Re-Accreditation must return the completed Application Form to the Executive Officer at least two months before the expiry of the Accredited Practitioner's current term of Accreditation.

(c) It is the personal responsibility of the Accredited Practitioner to ensure that timeframes are met for Re-Accreditation and a failure to do so may result in expiry of Accreditation.

(d) Subject to Operator policy, the processes for Re-Accreditation, including the processes for re-Credentialing and re-defining the Scope of Clinical Practice of Accredited Practitioners are the same as for Initial Accreditation, except that rights of appeal are as set out in By-Law 29.

22. RESIGNATION OR EXTENDED ABSENCE OF AN ACCREDITED PRACTITIONER

(a) An Accredited Practitioner who intends to cease treating Patients at a Facility either indefinitely or for an extended period must notify their intention to the Executive Officer. Accreditation will be taken to be relinquished from the date specified in the notification.

(b) An Accredited Practitioner in this situation must, whenever practicable, advise the Executive Officer before the end of his or her normal Patient bookings and clinical activities and must ensure that upon ending clinical activities, any remaining Patients are either discharged or referred with appropriate consent to the care of another Accredited Practitioner to ensure continuous cover.

(c) It is the responsibility of the Accredited Practitioner to notify his or her own Patients and any known carers or legal guardians of their Patients of any proposed changes to their care arrangements.

23. TERMS AND CONDITIONS OF ACCREDITATION

The continued Accreditation of a Practitioner is conditional on the Practitioner:

(a) complying with all applicable laws, these By-Laws, policies and procedures of the Operator and the Facility;

(b) ensuring compliance with, or assisting the Operator to comply with, any Commonwealth or State mandated service capability frameworks, licensing requirements or minimum standards, and any legislation imposing obligations upon the Facility;

(c) complying with the Operator's expectations regarding standard of conduct and behaviour, including conducting themselves and behaving at all times in accordance with:

(i) the Behavioural Standards and not engaging in Egregious Behaviour or Disruptive Behaviour;

(ii) the Code of Conduct and Code of Ethical Standards for Catholic Health and Aged Care Services in Australia or their (or either of their) replacement;

(iii) the Code of Ethics of the Australian Medical Association or any other relevant professional code of ethics;

(iv) the codes of practice and conduct, as well as associated guidelines and policies, of any specialist college or professional body or regulatory body of which the Accredited Practitioner is a member or registered;

(v) the philosophy, mission and values of the Operator;

and, upon request by the Executive Officer, the Accredited Practitioner is required to meet with the Executive Officer to discuss matters in (i) to (v) above, or any other matter arising out of these By-Laws;

(d) recognising that endorsement, modelling and championing by peers of the Behavioural Standards is critical to achieving and exceeding the Behavioural Standards with respect to all Accredited Practitioners. As such, any Accredited Practitioner who identifies a breach of the Behavioural Standards by another Accredited Practitioner is expected to promptly report this to the Executive Officer. Any action by an Accredited Practitioner that may be perceived as a reprisal for making such a report will be regarded as a breach of the Behavioural Standards;

(e) continuously providing clinical care based on best available evidence and/or standards of care that are well recognised by peers;

(f) maintaining their professional registration with their Registration Board, acting within the limits of their professional registration and providing documentary evidence of registration to the Facility annually or when requested;

(g) observing all reasonable requests made by the Facility or the Operator with regard to personal conduct in the Facility and with regard to the provision of services within the Facility;

(h) in respect of professional indemnity insurance:

(i) maintaining Adequate Professional Indemnity Insurance consistent with the Scope of Clinical Practice sought or held and at a level approved by the Operator;

(ii) annually (or when requested) providing the Facility or the Operator with evidence of Adequate Professional Indemnity Insurance; and

(iii) advising the Executive Officer of the Facility immediately of any material changes to the level of cover or conditions associated with their professional indemnity insurance including the termination, non-renewal or application of conditions or limitations with respect to that insurance;

(i) advising the Executive Officer immediately and follow up with written notification within 2 business days upon becoming aware of:

(i) being the subject of an investigation or inquiry instigated by, or an adverse finding made by, a Registration Board, the Australian Health Practitioner Regulation Agency, the Office of the Health Ombudsman, College, Police, the Coroner, or other investigative, disciplinary or professional body, including details of the nature of the investigation or inquiry, irrespective of whether this relates to a Patient of the Facility;

(ii) a reportable death relating to a Patient of the Facility and subsequent notification of a coronial inquest;

(iii) adverse outcomes or unexpected complications relating to a Patient of the Facility;

(iv) a written complaint from a Patient of the Facility relating to care provided by the Accredited Practitioner or staff of the Facility;

(v) written notification in relation to concerns or investigation from a private health insurance fund, Medicare or professional services review arising from services provided to a Patient of the Facility;

(vi) receipt of an initial notice or notice of claim pursuant to the *Personal Injuries Proceedings Act*, or service of court proceedings, making a compensation claim relating to care provided by the Accredited Practitioner with respect to a Patient of the Facility;

(vii) the withdrawal or suspension of the Accredited Practitioner's registration or upon limitations or conditions being imposed upon the Accredited Practitioner's right to practise or other adverse findings by their Registration Board or by virtue of undertakings given by the Accredited Practitioner to their Registration Board;

(viii) professional indemnity insurance being made conditional or not renewed, or should limitations be placed on professional indemnity insurance, or should there be denial of indemnity for a compensation claim relating to a Patient of the Facility;

(ix) their authorised Scope of Clinical Practice being changed, or their right to practise being denied, suspended, terminated, limited, made conditional or withdrawn (other than for health facility need and/or capability reasons) in any other health facility;

(x) being the subject of any criminal investigation or conviction, including for a sex or violence offence, and providing authority to the Facility to conduct a criminal history check with the appropriate authorities at any time;

(xi) incurring an illness or disability which may adversely affect their Current Fitness; or

(xii) matters likely to impact upon the reputation of the Facility or the Operator;

(j) keeping the Executive Officer continuously informed of matters notified pursuant to the preceding By-Law 23(i);

(k) participating in any clinical quality assurance, quality improvement and clinical risk management programs approved by the Medical Advisory Committee;

(l) participating in formal on call arrangements as required by the Facility or the Operator, following advice from the relevant Medical Advisory Committee to the Executive Officer or Chief Executive Officer of the need for on call rosters in disciplines necessary for safe patient care in any Facility;

(m) excepting the Operator's employees, not holding themselves out as representing the Operator or any Facility in any circumstances, including the use of Facility or the Operator letterhead, unless with the express written permission of the Executive Officer with the concurrence of the Chief Executive Officer;

(n) being available, or deputising an appropriately qualified Accredited Practitioner, for emergency call to the Accredited Practitioner's Patients;

(o) participating in reasonable education activities of the staff as required particularly in relation to any junior medical staff; and

(p) seeking the approval pursuant to these By-Laws and, where relevant, a human research ethics committee in regard to any New Clinical Service, Procedure or Other Intervention to treat Patients.

24. SAFETY AND QUALITY

The continued Accreditation of a Practitioner is conditional on the Practitioner adhering to the following expectations:

Admission, Availability, Patient Care, Utilisation, Communication and Discharge

(a) The Accredited Practitioner admitting or treating Patients and fully utilising allocated operating theatre and procedural facilities on a regular basis and being an active provider of services. If there has been no or limited activity or inadequate use of allocated operating theatre time or procedural facilities over the preceding 12 months, as determined by the Executive Officer, a show cause process may be initiated pursuant to this provision of the By-Laws. The show cause process may result in notification of suspension or termination of Accreditation due to insufficient utilisation;

(b) Accredited Practitioners must strictly adhere to approved Scope of Clinical Practice and any associated conditions or requirements. Quality improvement reviews will be conducted to assess adherence to approved Scope of Clinical Practice, as well as ongoing evaluation, monitoring and review of Credentials. Action may be taken pursuant to these By-Laws with respect to non-compliance with these By-Laws, non-compliance with approved Scope of Clinical Practice, or lack of meaningful response to the results of quality improvement reviews;

(c) Accredited Practitioners who admit Patients must accept complete responsibility for those Patients. Accredited Practitioners must ensure that they are readily available to treat and care for those Patients at all times, or failing that, other arrangements as permitted by these By-Laws are put in place to ensure continuity of Patient care;

(d) Accredited Practitioners must attend in person upon all Patients admitted or required to be treated by them as frequently as is required by the clinical circumstances or as reasonably requested by Facility staff. Absent special circumstances, an Accredited Practitioner must review a Patient in person within 24 hours of the Patient being admitted under that Accredited Practitioner, or within a shorter timeframe if clinically appropriate or if requested by Facility staff. Prior to the initial attendance, the Accredited Practitioner must provide adequate written instructions for management of the Patient. Absent special circumstances that are recorded in the medical record, an Accredited Practitioner must thereafter review the Patient within clinically appropriate timeframes, which at a minimum must be in person 24 hourly or through their on call or locum cover. If Accredited Practitioners are unable to personally provide the level of care set out in this By-Law, the Accredited Practitioner must secure the agreement of another Accredited Practitioner to provide the care and must notify the Executive Officer or Director of Nursing of the Facility in writing of this arrangement;

(e) Accredited Practitioners must be available to provide instructions by telephone in a timely manner. Alternatively, the Accredited Practitioner must make arrangements with another Accredited Practitioner to assist or must put in place with prior notice appropriate arrangements in order for another Accredited Practitioner to assist, and shall advise the Executive Officer or Director of Nursing of the Facility in writing of this arrangement;

(f) Accredited Practitioners must support the NSQHS for recognising and responding to acute deterioration, and the Operator and Facility policies with respect to clinical management of patient deterioration;

(g) It is the responsibility of Accredited Practitioners to ensure any changes to contact details are notified promptly, that 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. Accredited Practitioners must notify in writing an emergency contact of another Accredited Practitioner with the same Scope of Clinical Practice who has agreed to assist if immediate instructions or attendance is required and the Accredited Practitioner cannot be contacted;

(h) Accredited Practitioners must ensure that they have in place on call and cover arrangements with Accredited Practitioner(s) at the Facility and that those arrangements are communicated in writing to the Executive Officer or Director of Nursing of the Facility, including but not limited to the name, contact details and period of cover. A locum must be approved in accordance with these By-Laws. Prior to taking leave, the Accredited Practitioner should ensure adequate handover and where possible avoid undertaking major surgery or procedures in circumstances where the post-operative care is to be transferred to a locum or on call Accredited Practitioner;

(i) Accredited Practitioners must familiarise themselves with and strictly adhere to the Operator and Facility policies with respect to surgical safety, including but not limited to completing and participating in pre-procedure and pre-anaesthetic checks, leading team time out and end of procedure checks and allowing Facility staff sufficient time to complete surgical safety requirements;

(j) Accredited Practitioners accept complete responsibility for, and must directly supervise, Surgical Assistants who assist the Accredited Practitioner with surgical and other procedures;

(k) Accredited Practitioners must familiarise themselves with and comply with the Operator's targeted programs with respect to safety of Patient care. In particular, it is expected that Accredited Practitioners must strictly comply with Operator and Facility policies and procedures for medication, infection control, hand hygiene and venous thromboembolism prevention;

(l) Accredited Practitioners must work as part of a multi-disciplinary team, including effective communication – written and verbal, to ensure the best possible care for Patients. Accredited Practitioners must at all times ensure that they provide effective communication to other members of the team, referring doctors, the executive, Patients and the Patient's family or next of kin;

(m) Accredited Practitioners must consider their own potential fatigue and that of other staff involved in provision of Patient care, when making Patient bookings and in utilising operating theatre and procedural Facility time. This includes the total number of Patients, number of consecutive patients in one day or on a list, number of consecutive working days, total hours worked in a day and over the preceding days and responsibilities at other health facilities;

(n) Adequate instructions and clinical handover must be given to Facility staff and other health practitioners (including on-call and locum cover) to understand and to provide the care the Accredited Practitioner requires to be delivered. The Accredited Practitioner must directly supervise the care provided by the Facility staff and other health practitioners;

(o) If care is be formally transferred to another Accredited Practitioner, this must be noted on the Patient medical record and communicated to the responsible nursing staff member;

(p) Accredited Practitioners must ensure that their Patients are not discharged without review by and the written approval of the Accredited Practitioner, complying with the discharge requirements of the Facility. The Accredited Practitioner must ensure all information reasonably necessary to ensure continuity of care after discharge is provided to the Patient, Patient's carer, referring practitioner, general practitioner and/or other treating practitioners.

Treatment and Financial Consent

(a) Accredited Practitioners must obtain and document fully informed consent to 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 standards (including section 3.5 of the *Good Medical Practice: A Code of Conduct for Doctors in Australia*) and accepted legal standards (including section 22 *Standard of care for professionals* of the *Civil Liability Act (Qld))*. 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;

(b) It is not permissible for the Accredited Practitioner to delegate responsibilities with respect to obtaining fully informed consent to treatment;

(c) The consent process for treatment must satisfy the Operator's *Corp CP 01 Consent / Verification of Informed Consent* policy and procedures, as amended or replaced;

(d) Given the importance of the treatment consent documentation completed by the Accredited Practitioner and Patient to the surgical safety processes, and requirement for compliance with associated policies and procedures, admissions will not be accepted and/or surgery/procedures will not proceed until complete compliance has occurred;

(e) Accredited Practitioners must provide full financial disclosure and obtain and document fully informed financial consent from their Patients in accordance with medical standards (including in section 3.5 of the *Good Medical Practice: A Code of Conduct for Doctors in Australia*), legal standards, contractual obligations with health funds and policies of the Facility.

Patient Records

(a) Accredited Practitioners must ensure that Patient medical records held by a Facility contain adequate documentation of the care and treatment provided by the Accredited Practitioner, which will be complete, accurate, legible and contemporaneous, including in relation to each attendance upon the Patient, with the entries dated, timed and signed, that must include all relevant information and documents reasonably necessary to allow Facility staff and other Accredited Practitioners to care for Patients, including instructions, orders and treatment plans;

(b) Patient records including entries made by the Accredited Practitioner must satisfy the Operator's policy requirements, legislative requirements, the content and standard required by the Australian Council on Healthcare Standards, accreditation requirements, health fund obligations, Queensland Health and other bodies requirements;

(c) If a contemporaneous record is not possible, for example if instructions are provided by telephone, then at the next reasonable opportunity the Accredited Practitioner must place a copy of their contemporaneous notation in the Facility medical record or must make a retrospective entry in the Facility medical record;

(d) Complications, incidents, variations and deviations from standard clinical pathways and expectations must be recorded by the Accredited Practitioner in the Facility medical record as well as being brought to the attention of Facility staff;

(e) A procedure report must be completed (where applicable), including a detailed account of the findings, technique undertaken, complications and post procedure orders and this is placed in the Patient records held by the Facility;

(f) An anaesthetic report must be completed (where applicable) and this is placed in the Patient records held by the Facility;

(g) If the Accredited Practitioner requires access to or a copy of the Patient medical records held by the Facility, for a purpose not directly related to ongoing clinical care of the Patient, then the Accredited Practitioner must submit to the Facility a consent for release signed by the Patient or substituted decision maker;

(h) Accredited Practitioners must record in the Facility medical record all data required by the Facility, including but not limited to data required to carry out coding, to comply with reporting obligations and to meet the requirements of health funds, and must ensure that all Pharmaceutical Benefits Scheme prescription requirements and Queensland Health certificates are completed in accordance with Facility and regulatory requirements.

Safety and Quality Improvement, Risk Management and Requirements of Regulatory Agencies

(a) Accredited Practitioners are encouraged to attend and meaningfully participate in the Facility's relevant safety, quality, risk management, education and training activities, and Craft Group meetings (the latter may include clinical audit, morbidity and mortality review, clinical oversight and peer review activities in which the Accredited Practitioner's outcomes and statistics are being considered);

(b) Accredited Practitioners are encouraged to inform themselves of the safety and quality initiatives instituted by the Facility based upon its own safety and quality program, or safety and quality initiatives, programs or standards of Queensland or Commonwealth health departments, statutory bodies or safety and quality organisations. Accredited Practitioners must participate in and ensure compliance with these initiatives, programs and standards, whether these apply directly to the Accredited Practitioner or require assistance from the Accredited Practitioner to ensure compliance by the Facility. Accredited Practitioners must particularly be familiar with, ensure compliance with and assist the Facility to comply with the NSQHS and Clinical Care Standards of the Australian Commission on Safety and Quality in Health Care;

(c) Accredited Practitioners must maintain and comply with the ongoing minimum competency and continuing professional development requirements of their professional college with respect to the Scope of Clinical Practice granted, including with respect to any sub-specialty areas and the minimum annual procedure requirements in order to maintain competency with respect to that procedure. Accredited Practitioners must provide all necessary information, documentation and assistance so that quality improvement reviews may be conducted with respect to compliance;

(d) Accredited Practitioners must report, and provide all relevant information, to the Facility about incidents, complications, adverse events, complaints, reportable deaths to the Coroner and other reportable events in accordance with the Operator's policy, procedures and regulatory obligations. Where required by the Executive Officer, Accredited Practitioners must assist with, provide relevant information and participate in incident management, complaint management, investigation, reviews (including root cause analysis and other systems reviews) and open disclosure;

(e) The Facility requires the support of all Accredited Practitioners accredited at a Facility and Facility Staff in order to achieve a high level of safety and quality. In support of this objective, the Operator encourages all Accredited Practitioners and Facility staff to report any safety and quality concerns, including if it relates to the practice of an Accredited Practitioner or Facility staff member. Any action by an Accredited Practitioner that may be perceived as a reprisal for making such a report will be regarded as a breach of the Behavioural Standards;

(f) Accredited Practitioners acknowledge and agree that, as part of its clinical governance and safety obligations to patients, the Operator or Facility may conduct case reviews with respect to the care provided to a Patient or Patients of the Accredited Practitioner, that may involve obtaining external opinion;

(g) Accredited Practitioners must participate in risk management activities and programs, including by assisting in the implementation of risk management strategies and recommendations from root cause analysis and system reviews;

(h) Accredited Practitioners must provide all reasonable and necessary assistance where the Facility requests assistance from the Accredited Practitioner in order to comply with or respond to a valid legal request or order; in order to respond to requests from Government, regulators or other bodies (including but not limited to Queensland Government and its agencies or departments, Private Health Regulation, Office of the Health Ombudsman, health funds, Coroner, Police, Commonwealth Government and its agencies or departments).

25. REQUEST FOR VARIATION OF SCOPE OF CLINICAL PRACTICE

(a) Any Accredited Practitioner may at any time request a variation to their Scope of Clinical Practice.

(b) The process for consideration and determination of a request for variation to the Scope of Clinical Practice is the same as for an initial consideration and determination of the Scope of Clinical Practice. The Chief Executive Officer, Executive Officer or delegate of either may waive the requirement to submit evidence of specific Credentials if satisfied that there has been no change to those Credentials since they were lastreviewed.

(c) Requests for a variation to an Accredited Practitioner's Scope of Clinical Practice that constitute a New Clinical Service, Procedure or Other Intervention must be dealt with in accordance with By-Law 45 rather than this by-law 25.

26. SUSPENSION OF ACCREDITATION OR IMPOSITION OF CONDITIONS UPON ACCREDITATION

(a) The Executive Officer may in his/her sole discretion by notice in writing place conditions on an Accredited Practitioner's Scope of Clinical Practice or suspend their Accreditation until further notice if in the opinion of the Executive Officer:

(i) to do so is reasonably considered to be in the interests of Patient care or safety;

(ii) to do so is reasonably considered to be in the interests of staff welfare or safety;

(iii) the Accredited Practitioner has failed to observe the terms and conditions of their Accreditation, including these By-Laws or the policies and procedures of the Facility or Operator;

(iv) the behaviour or conduct of the Accredited Practitioner may compromise the efficient operation or the interests of the Facility or Operator;

(v) the behaviour or conduct of the Accredited Practitioner may harm the reputation of the Facility or the Operator;

(vi) it is appropriate action based upon a finalised review conducted pursuant to these By-Laws;

(vii) it is appropriate action based upon a matter notified or required to be notified pursuant to these By-Laws;

(viii) serious and unresolved issues have been raised in relation to the Accredited Practitioner; or

(ix) there are other issues or concerns in respect of the Accredited Practitioner that is considered to be a ground for suspension or imposition of conditions.

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

(i) the suspension;

(ii) the period of suspension;

(iii) the reasons for the suspension;

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

(v) the right of appeal (if available), the appeal process and the time frame for an appeal.

(c) As an alternative to immediate suspension the Executive Officer may elect to deliver a show cause notice to the Accredited 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 Accredited Practitioner, including a response why the Accredited Practitioner may consider suspension is not appropriate;

(iv) any actions that must be performed for the suspension not to occur and the period within which those actions must be completed, if applicable and appropriate in the circumstances;

(v) a timeframe in which a response is required from the Accredited Practitioner to the show cause notice; and

(vi) following receipt of the response the 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 Accredited Practitioner will be advised that suspension will not occur, however this will not prevent the Executive Officer from taking other action at this time, including imposition of conditions, and will not prevent the Executive Officer from relying upon these matters as a ground for suspension or termination in the future;

(d) Immediately upon being suspended, an Accredited Practitioner must, in consultation with their Patients, assign those Patients to other Accredited Practitioners.

(e) In the event that the suspended Accredited Practitioner fails to assign their Patients to other Accredited Practitioners, the Executive Officer may inform those Patients of the Accredited Practitioner's suspension and request the consent of those Patients to arrange for alternative treatment and care by another Accredited Practitioner.

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

(g) The Accredited Practitioner who has had his/her Accreditation suspended shall have the rights of appeal established by these By-Laws.

(h) The Executive Officer will notify the Chief Executive Officer of any suspension of Accreditation.

(i) The Executive Officer in lieu of a suspension may elect to impose conditions on Accreditation or Scope of Clinical Practice and will follow the same process as set out above for suspension of Accreditation.

(j) Accredited Practitioners acknowledge and agree, as part of the acceptance of Accreditation, that a suspension of Accreditation or imposition of conditions upon Accreditation carried out in accordance with these By-Laws does not result in an entitlement to any compensation, including for economic loss or reputational damage.

27. TERMINATION OF ACCREDITATION

(a) Accreditation will immediately terminate, without any avenue for appeal pursuant to these By-Laws, based upon any of the following grounds:

(i) the Accredited Practitioner ceases to be registered with their relevant Registration Board;

(ii) the Accredited Practitioner ceases to maintain Adequate Professional Indemnity Insurance covering the Scope of Clinical Practice; or

(iii) a contract of employment (for example with respect to an employed Medical Practitioner) or to provide services is terminated or ends, and is not renewed.

(b) In addition to the immediate termination rights referred to in clause 27(a), the Board may terminate the Accreditation of an Accredited Practitioner on the following grounds, or if it appears based upon the information available the following has occurred:

(i) based upon any grounds supporting suspension of Accreditation or imposition of conditions pursuant to By-Law 26 and it is reasonably considered that suspension of Accreditation or imposition of conditions is an insufficient response in the circumstances;

(ii) the relevant Facility cannot or elects not to provide the facilities or support services necessary for safe service provision, or the Facility no longer needs or requires the clinical services in accordance with the Facility's Needs or Capabilities and, in either case, the Practitioner's Scope of Clinical Practice cannot be altered by mutual agreement;

(iii) where the Practitioner is not an employee, the Practitioner becomes incapable of performing his/her duties for a continuous period of 6 months, the Accredited Practitioner is not regarded by the Chief Executive Officer as having the appropriate Current Fitness to retain Accreditation or the Scope of Clinical Practice, or the Chief Executive Officer does not have confidence in the continued appointment of the Accredited Practitioner;

(iv) the Practitioner is found guilty of professional misconduct or unprofessional conduct (however termed) by their Registration Board, any other investigative, disciplinary or professional body;

(v) conditions have been imposed by, or undertakings agreed with, the Accredited Practitioner's Registration Board that restricts practice or imposes supervision and the Facility does not have capacity to meet or is not willing to meet the impact of the conditions imposed or undertakings agreed;

(vi) the Practitioner materially fails to observe the terms and conditions of their Accreditation, including these By- Laws or the policies and procedures of the relevant Facility;

(vii) the Accredited Practitioner has engaged in conduct which in the opinion of the Chief Executive Officer is likely to bring the Accredited Practitioner into professional disrepute;

(viii) the Accredited Practitioner has engaged in conduct which in the opinion of the Board is likely to harm the reputation of the relevant Facility or the Operator;

(ix) the Accredited Practitioner does not have the continuing confidence of the Board or the Board does not regard the Accredited Practitioner as having Current Fitness; or

(x) there are other issues or concerns in respect of the Accredited Practitioner that is considered to be a ground for termination.

(c) The Board or delegate shall notify the Accredited Practitioner of:

(i) the fact of termination;

(ii) the reasons for the termination; and

(iii) if a right of appeal is available in the circumstances, the right of appeal, the appeal process and the time frame for an appeal.

(d) As an alternative to an immediate termination, the Board may elect to deliver a show cause notice to the Accredited 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 Accredited Practitioner, including a response why the Accredited 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 Accredited Practitioner to the show cause notice; and following receipt of the response the Board will determine whether the Accreditation will be terminated. If termination is to occur notification will be sent in accordance with this By-Law. Otherwise, the Accredited Practitioner will be advised that termination will not occur, however this will not prevent the Board from taking other action at this time, including imposition of conditions, and will not prevent the Board from relying upon these matters as a ground for suspension or termination in the future.

(e) Accredited Practitioners acknowledge and agree, as part of the acceptance of Accreditation, that a termination of Accreditation carried out in accordance with these By-Laws does not result in an entitlement to any compensation, including for economic loss or reputational damage.

28. REVIEW OF ACCREDITATION AND/OR SCOPE OF CLINICAL PRACTICE

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

(i) Patient health or safety may be compromised;

(ii) the rights or interests of a Patient, staff, another Accredited Practitioner or someone engaged in or at the Facility may be adversely affected;

(iii) Current Fitness, competence or performance;

(iv) compatibility with a Facility's Needs or Capabilities;

(v) confidence in the Accredited Practitioner;

(vi) compliance with the Behavioural Standards;

(vii) compliance with these By-laws or Scope of Clinical Practice;

(viii) a ground for suspension or termination of Accreditation may arise;

(ix) the efficient operation of the Operator or a Facility could be threatened or disrupted;

(x) the potential loss or breach of a Facility's licence or accreditation;

(xi) the potential to bring the Operator or a Facility into disrepute; or

(xii) arising from a notification required to be provided pursuant to these By-Laws.

(b) The Board or Chief Executive Officer will determine whether the process to be followed is an:

(i) Internal Review; or

(ii) External Review.

(c) Prior to determining whether an Internal Review or External Review will be conducted, a representative of the Board or Chief Executive Officer may elect to facilitate a meeting with the Accredited Practitioner, along with any other persons considered appropriate, advise of the concern, and invite a preliminary response from the Accredited Practitioner before a decision is made whether a review will proceed, and if so, the type of review.

(d) The Board or Chief Executive Officer will make a determination whether to impose an interim suspension or conditions upon Accreditation pending the outcome of the review, and if this occurs, it will be done in accordance with these By-Laws, except that the appeal provisions pursuant to these By-Laws will not apply with respect to an interim suspension or conditions.

(e) In addition or as an alternative to conducting an Internal or External Review, the Board or Chief Executive Officer may notify the OHO and/or other professional body responsible for the Accredited Practitioner of details of the concerns raised if:

(i) required by legislation,

(ii) the Board or Chief Executive Officer consider it is in the interests of Patient care or safety to do so,

(iii) it is in the interests of protection of the public (including Patients at other facilities) to do so: or

(iv) it is considered that the OHO or professional body is more appropriate to investigate and take necessary action.

Following the outcome of any action taken by the OHO and/or other professional body the Board or Chief Executive Officer may elect to take action, or further action, under these By-laws.

(f) For the avoidance of any doubt, an Internal or External Review is not a necessary precondition to suspension, termination or imposition of conditions upon Accreditation, and the Board or Chief Executive Officer may decide to proceed directly to any of these actions.

Internal Review

(a) A person or persons internal to the Operator will undertake an Internal Review.

(b) At the discretion of the Board or the Chief Executive Officer, an Internal Review may be conducted by:

(i) the Medical Advisory Committee or Credentialing Committee; or

(ii) other appropriate persons.

External Review

An External Review will be undertaken by a person or persons external to the Operator as appointed by the Board or the Chief Executive Officer.

Process for Internal Review or External Review

(a) The terms of reference, process and reviewers will be as determined by the Board or Chief Executive Officer.

(b) The process will ordinarily include the opportunity for submissions from the Accredited Practitioner, which may be written and/or oral.

(c) The Board or Chief Executive Officer will notify the Accredited Practitioner in writing of the review, the terms of reference, process and reviewer(s).

(d) The reviewer will provide a report on the findings of the review to the Chief Executive Officer or to the Board.

(e) Following consideration of the report, the Board is required to make a determination of whether or not to continue (including with conditions), amend, suspend or terminate Accreditation in accordance with these By-Laws.

(f) The Board's delegate will notify the Accredited 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 Accredited Practitioner shall have the rights of appeal established by these By-Laws in relation to the final determination made by the Board following an Internal Review or External Review if a decision is made to amend, suspend, terminate or impose conditions on Accreditation.

29. AVAILABILITY OF A RIGHT OF APPEAL

(a) An Accredited Practitioner has the right of appeal under By-Law 30 in relation to a decision:

(i) regarding an application for Re-Accreditation (By-Law 21);

(ii) regarding suspension or termination of their Accreditation (By-Laws 26 and 27 unless otherwise prohibited pursuant to By-Law 27(a)) ; or

(iii) regarding a review of accreditation and/or Scope of Clinical Practice but only to the extent permitted under By-Law 28 so far as relates to an Internal Review or an External Review.

(b) There is no right of appeal in relation to any other decision made pursuant to these By-Laws:

30. APPEAL PROCEDURE

(a) Any appeal by an Accredited Practitioner (**Appellant**) pursuant to the By-Laws must be in writing and must be lodged with the Chairman of the Board within 21 days of decision that the Appellant wishes to appeal.

(b) Any appeal must be accompanied by a request by the Appellant for a hearing by an appeal committee and must set out in detail the grounds upon which the Appellant relies.

(c) If the notice of appeal is not received by the Chairman of the Board within the 21 day period, the Accredited Practitioner will be deemed to have waived his/her right to appeal.

(d) Lodgement of an appeal does not result in a stay of the decision under appeal and the decision will stand and be actioned accordingly unless the Board (in its absolute discretion) decides otherwise.

(e) The Board will, within a reasonable time following receipt of the appeal, convene an appeal hearing committee comprised of at least three (3) persons and will include:

(i) a senior healthcare professional external to any Facility of the Operator, appointed by the Board;

(ii) a member of the relevant medical college/association or relevant professional college/association to which the Appellant belongs (if applicable), appointed by the Board; and

(iii) at least one additional professional representative, appointed by the Board, who brings specific expertise to the decision under appeal and who must be independent of the decision under appeal, but who may be an Accredited Practitioner (**Appeal Hearing Committee**).

(f) Before accepting the appointment, the nominees to the Appeal Hearing Committee will confirm that they do not have a known conflict of interest with the Appellant or the Board and will sign a confidentiality agreement. Once all members of the Appeal Hearing Committee have accepted the appointment, the Chairman of the Board will notify the Appellant of the members of the Appeal Hearing Committee.

(g) The Board will appoint the chairman of the Appeal Hearing Committee. The chairman of the Appeal Hearing Committee shall determine any questions of process and procedure for the appeal and for the Appeal Hearing Committee. The appeal will be conducted informally and the rules of evidence will have no application.

(h) The Facility or Operator (as the case made be) will inform the Board and chairman of the Appeal Hearing Committee of a nominated representative (who is not a member of the Board) who will appear at the Appeal Hearing Committee to advocate in support of the decision under appeal (**Nominated Representative**).

(i) The Chairman of the Board will schedule with members of the Appeal Hearing Committee, a date for the hearing of the appeal within 30 days of the Appeal Hearing Committee being convened and the Appellant and Nominated Representative will be notified of the hearing date 21 days in advance.

(j) At least 10 days prior to the hearing of the appeal, the Chairman of the Board will provide to the Appeal Hearing Committee, the Appellant and Nominated Representative particulars of the reasoning in support of the decision made.

(k) The Appellant must at least 5 days prior to the hearing of the appeal deliver to the Appeal Hearing Committee, the Chairman of the Board and Nominated Representative a submission made by the Appellant in support of the appeal, together with any supporting documentary evidence.

(l) The Appellant and Nominated Representative will have the opportunity to make oral submissions to the Appeal Hearing Committee and to respond to questions of the Appeal Hearing Committee.

(m) Failure by the Appellant to attend at the hearing of the appeal will constitute a withdrawal of the appeal.

(n) Both the Appellant and the Nominated Representative will be entitled to have present at the hearing of the appeal, a legal representative who may act as an advisor but not as an advocate.

(o) Upon the conclusion of the oral submissions, the hearing of the appeal will be closed and the Appeal Hearing Committee will, at a time convenient to it, conduct its deliberations in the absence of the Appellant, Nominated Representative and legal representative of those parties.

(p) Within 14 days from the date of the hearing, the Appeal Hearing Committee will make a written recommendation to the Board, including reasons, which recommendation may be made by a majority of members of the Appeal Hearing Committee. If there is an even number of members of the Appeal Hearing Committee, the chairman of the Appeal Hearing Committee has a second or casting vote.

(q) The Board will make a final and binding decision on the appeal, taking into consideration the recommendation of the Appeal Hearing Committee. The Board must notify the Appellant of its decision in writing within 15 days of making its decision. The decision of the Board is final and binding, and there is no further appeal allowed under these By-Laws from this decision.

PART C - MEDICAL ADVISORY COMMITTEE, CREDENTIALING COMMITTEE AND CLINICAL REVIEW COMMITTEE

31. COMPOSITION OF MEDICAL ADVISORY COMMITTEES

(a) Subject to By-Law 10(e) for each Facility mentioned in By-Law 10(f) there must be established and maintained a separate Medical Advisory Committee.

(b) The members of a Medical Advisory Committee, including a chairman and deputy chairman, will be appointed by the Executive Officer, following the approval of the Chief Executive Officer.

(c) The membership of a Medical Advisory Committee will comprise:

(i) at least 5 Accredited Practitioners including at least one from each of the major specialty groups of the Facility;

(ii) the Executive Officer or his/her delegate;

(iii) the Executive Director of Medical Services; and

(iv) the Director of Nursing.

The Chief Executive Officer or his/her delegate is entitled to attend any meeting of a Medical Advisory Committee as an ex officio member.

(d) A Medical Advisory Committee may co-opt the services of any other person if it considers this necessary however that person will have no voting rights at any meeting of the Medical Advisory Committee or any sub- committee.

32. ROLE OF MEDICAL ADVISORY COMMITTEE

(a) The Medical Advisory Committee provides advice to the Executive Officer or delegate.

(b) The roles of the Medical Advisory Committee are to:

(i) be the formal organisational structure through which the views of the Accredited Practitioners of the Facility are formulated and communicated;

(ii) provide a means by which Accredited Practitioners can participate in the policy making and planning processes of the Facility;

(iii) advise on a continuing education program for Accredited Practitioners or junior staff where appropriate;

(iv) advise the Executive Officer of appropriate policies regarding the clinical organisation of the Facility;

(v) assist in identifying health needs of the community and advise the Executive Officer on appropriate services which may be required to meet these needs;

(vi) participate in the planning, development and implementation of quality programs of the Facility;

(vii) endeavour to ensure that the delivery of patient care in the Facility is maintained at an optimal level of quality and efficiency given the resources locally available; and

(viii) ensure that a formal mechanism for review of clinical outcomes and management is established and ensure Accredited Practitioners engage in that mechanism in accordance with these By-Laws.

(c) No office bearer of the Medical Advisory Committee nor any of its members or sub-committees may hold themselves out as representing the Operator or the Facility in any circumstances unless with the express written permission of the Chief Executive Officer.

33. MEETINGS OF MEDICAL ADVISORY COMMITTEE

(a) Ordinary meetings of a Medical Advisory Committee must be held not less than 4 times a year at a time and place to be determined by the chairman in consultation with the Executive Officer or delegate provided that at least 14 days' notice must be given of every ordinary meeting.

(b) A special meeting of a Medical Advisory Committee may be called by the chairman of the Medical Advisory Committee, with members being given at least 7 days' notice of the meeting.

(c) Notice of a special meeting must specify the business to be considered and, in the absence of unanimous agreement of members of the Medical Advisory Committee to the contrary, no business of which notice has not been given may be considered at the meeting.

(d) In an emergency, the Chief Executive Officer or the Executive Officer may act without advice from the Medical Advisory Committee in circumstances where that advice ordinarily would be required. The Medical Advisory Committee must consider the issue at a subsequent meeting.

34. PROCEEDINGS OF MEDICAL ADVISORY COMMITTEE

(a) Entitlement to vote at meetings of a Medical Advisory Committee is given under these By-Laws to the Accredited Practitioner members of the Committee.

(b) The following quorum requirements apply:

(i) quorum will be a simple majority of members of a Medical Advisory Committee; and

(ii) a decision may be made by a Medical Advisory Committee without a meeting if all committee members sign their consent on a document (which may have counterparts) which states the decision.

(c) All questions, except as otherwise provided in these By-Laws, must be decided by a show of hands, or where demanded by a member entitled to vote, a ballot. The chairman of the Medical Advisory Committee will have a deliberative and, in the case of equal votes, a casting vote.

(d) The Medical Advisory Committee may hold any meeting by electronic means as long as participants can be heard and can hear even if they are not in the same place. The requirements of these By-Laws still apply to a meeting of this kind.

(e) Minutes of all meetings of a Medical Advisory Committee must be recorded and copies of the minutes provided to the Board through the Chief Executive Officer for consideration.

(f) Minutes must be distributed to all those entitled to attend meetings of a Medical Advisory Committee before the next meeting.

(g) No business may be considered at a meeting of a Medical Advisory Committee until the minutes of the previous meeting have been confirmed or otherwise disposed of. No discussion of the minutes is permitted except as to their accuracy.

(h) Minutes of a meeting must be confirmed by resolution and signed by the chairman at the next meeting. Minutes confirmed and signed in that way will be taken as evidence of proceedings of that meeting.

35. COMPOSITION OF THE CREDENTIALING COMMITTEE

(a) The membership of the Credentialing Committee will comprise:

(i) the Chief Executive Officer;

(ii) the Director of Medical Services or other clinical officer of the Operator;

(iii) an Executive Officer; and

(iv) at least 4 Accredited Medical Practitioners.

The Credentialing Committee may also include other member/s of the Operator's staff provided that the majority of members appointed to the Committee at any time are Accredited Practitioners.

Any member of the Committee whose application for Accreditation or Re-Accreditation or whose application to vary their Scope of Clinical Practice is being considered is excluded from a meeting of the Committee during that consideration.

(b) Subject to By-Laws 35(c) and 35(d), the Credentialing Committee will be appointed by the Board annually. The Board will appoint the chairman of the Credentialing Committee.

(c) In order to properly discharge its functions, the Credentialing Committee may at any time:

(i) identify and recommend to the Board the need to include a member on its committee with expertise in a specialised area in order to properly discharge its functions;

(ii) recommend to the Board a person to fill any casual vacancy on the Credentialing Committee; or

(iii) co-opt the services of other Accredited Practitioners, without the consent of the Board, for clearly defined purposes or where Practitioners on the Committee cannot determine a matter under these By-Laws because of a conflict of interest.

(d) The Board must consider any recommendation made to it by the Credentialing Committee pursuant to By-Laws 35(c)(i) and 35(c)(ii) and, if deemed appropriate, may add or substitute a member to the Committee at any time.

(e) Where an Accredited Practitioner is co-opted pursuant to By-Law 35(c)(iii), that person will be deemed to be a member of the Committee only for the purposes for which he or she is co-opted.

(f) Any member of the Credentialing Committee may resign as a member by giving at least one month's notice in writing of their intention to resign to the Chief Executive Officer.

36. ROLE OF THE CREDENTIALING COMMITTEE

(a) The Credentialing Committee is the committee that provides advice on Accreditation and Scope of Clinical Practice to the Chief Executive Officer as representative of the Board.

(b) The role of the Credentialing Committee is to:

(i) ensure that its members are aware of their obligations to act fairly and without bias and to avoid conflicts of interest and to maintain confidentiality;

(ii) ensure that all reasonable professional requirements of Accredited Practitioners are met;

(iii) advise and make recommendations to the Board through the Chief Executive Officer concerning clinical practice, services and other matters which might affect the ability of health professionals at any Facility to deliver the highest possible quality treatment and care to Patients;

(iv) develop and review criteria and monitor the effectiveness of a program of Credentialing and defining any Scope of Clinical Practice, if requested by the Board;

(v) evaluate the particular health services available at a Facility including those services required to support the Scope of Clinical Practice requested or held by all Practitioners at a Facility, as the case may be;

(vi) make a recommendation concerning the appropriate Scope of Clinical Practice and/or the Accreditation for a Practitioner to the Board, through the Chief Executive Officer:

(A) in response to applications for Accreditation or Re-Accreditation referred to the Credentialing Committee;

(B) based on an investigation and assessment of the Practitioner's Credentials; and

(C) taking into account current Scope of Clinical Practice (if any) and the Facility's Needs and Capabilities;

(vii) review the Scope of Clinical Practice and make a recommendation, to the Chief Executive Officer, concerning the appropriate Scope of Clinical Practice for a Practitioner to the Board in response to a request for a variation of their authorised Scope of Clinical Practice by a Practitioner;

(viii) make a recommendation, through the Chief Executive Officer, concerning the continuation, amendment, suspension or termination of the Scope of Clinical Practice and/or Accreditation of a Practitioner to the Board:

(A) if directed by the Board or Chief Executive Officer (that is, other than in response to applications for Accreditation or Re-Accreditation or variation of current Scope of Clinical Practice); and

(B) based on a review of the Practitioner's Credentials, which may include an assessment of any of Current Fitness, confidence held in that Practitioner and a Facility's Needs and Capabilities; and

(ix) review any proposed New Clinical Services, Procedures and Other Interventions, assessing the Facility's Needs and Capabilities and other matters which are considered relevant, and make a related recommendation on the amendment of the Scope of Clinical Practice of an Accredited Practitioner.

(c) The Credentialing Committee may request an applicant for Accreditation or Re-Accreditation or any Accredited Practitioner whose Scope of Clinical Practice is under review to provide evidence within a reasonable period of time of any aspect of their Credentials and/or submit written material in support of their requested Scope of Clinical Practice and/or present in person to the committee.

(d) The Credentialing Committee may recommend conditions on the Scope of Clinical Practice of any applicant for Accreditation or Re-Accreditation or any Accredited Practitioner whose Scope of Clinical Practice is under review, including, without limitation, requirements for participation in a formal mentoring and/or supervision program, requirements for monitoring and/or review of performance and requirements for procedural throughput for a designated period.

37. MEETINGS AND PROCEDURES OF CREDENTIALING COMMITTEE

The requirements for meetings and proceedings for the Credentialing Committee are the same as those provided for Medical Advisory Committees in By-Laws 33 and 34, after substituting "Credentialing Committee" for "Medical Advisory Committee".

38. COMPOSITION OF THE CLINICAL REVIEW COMMITTEES

(a) The membership of the Clinical Review Committee will comprise:

(i) the Facility Executive Officer;

(ii) the Director of Medical Services;

(iii) a Director of Nursing;

(iv) a Facility Quality Risk Manager; and

(v) at least 5 Accredited Medical Practitioners.

(b) The members of a Clinical Review Committee, including a chairman, will be appointed by the Executive Officer, with the concurrence of the Executive Director of Medical Services.

(c) The Clinical Review Committee may also include other member/s of the Facility's staff provided that the majority of members appointed to the Committee at any time are Accredited Practitioners.

(d) Any member of the Committee whose application for Accreditation or Re-Accreditation or whose application to vary their Scope of Clinical Practice is being considered is excluded from a meeting of the Committee during that consideration.

(e) The Chief Executive Officer or his/her delegate is entitled to attend any meeting of a Clinical Review Committee as an ex officio member.

39. ROLE OF THE FACILITY CLINICAL REVIEW COMMITTEE

The Facilities will have a clinical review committee, which will have the following objectives:

(a) assessment and evaluation of quality of health services including the review of clinical practices or clinical competence of persons providing those services;

(b) reviewing clinical outcomes to identify system or individual practices that impact on patient outcomes; and

(c) providing a forum for Accredited Practitioners to meet and discuss relevant clinical and system matters.

The clinical review and quality functions of the Clinical Review Committee are to:

(a) review clinical indicators;

(b) review mortality and morbidity reports;

(c) review adverse event trends related to clinical practice;

(d) promote participation in quality projects to achieve improved patient outcomes;

(e) review specific cases identified as an outcome of the reviews undertaken; and

(f) make system and process recommendations where appropriate

(g) notify the facility Executive Officer and Executive Director of Medical Services of any identified clinical issues and risks at the Facility.

40. MEETINGS OF FACILITY CLINICAL REVIEW COMMITTEE

(a) The Clinical Review Committee must meet at least twice per year for formal quality, morbidity and mortality review meetings or as otherwise required by the Executive Director of Medical Services.

(b) The chairman, or his or her delegate for this purpose, must record minutes of the meetings of the Clinical Review Committee.

(c) Minutes recorded at meetings must be distributed to the members of the Clinical Review Committee, in a timely manner.

(d) All minutes and actions arising from the meetings are to be forwarded to the Executive Director of Medical Services for relevant discussions with any risk management committee of the Operator.

41. MANDATORY ATTENDANCE AT FACILITY CLINICAL REVIEW COMMITTEE

(a) It is a Condition of Accreditation that:

(i) where a specific case involving an Accredited Practitioner's patient has been listed for review, the Accredited Practitioner must attend the meeting and/or provide a written report.

42. FACILITY MEDICAL CRAFT GROUPS

Accredited Practitioners are encouraged to actively engage within their specialty peer support Craft Group. The peer group support can be through individual Facility, regional or other professional links that allows for suitable continuous professional development.

PART D - GENERAL PROVISIONS

43. CONFLICT OF INTERESTS

(a) If a member of any Facility or Operator committee or a person authorised to attend any committee meeting has an actual or potential conflict of interest:

(i) in a matter that has been considered or is about to be considered at a meeting; or

(ii) in a thing being done or about to be done by a Facility or the Operator,

then the member or person must disclose the nature of that interest at the meeting.

(b) Subject to By-Laws 43(e) and 43(f), if a member of any Facility or Operator committee or a person authorised to attend any committee meeting has an actual or potential conflict of interest, the member or person:

(i) may not participate in the relevant discussion or resolution of any relevant interest or matter; and

(ii) is not eligible to exercise any office to which the actual or potential conflict of interest applies.

(c) For the purposes of By-Laws 43(a) and 43(b), an actual or potential conflict of interest includes but is not limited to:

(i) a direct or indirect financial interest;

(ii) a direct or indirect business, employment, or partnership relationship; and

(iii) a direct or indirect significant personal interest.

(d) A disclosure by a person at a meeting of the committee that the person:

(i) is a member, or is in the employment of, the specified company or other body;

(ii) is a partner or is in the employment of, or has a business relationship with, a specified person; or

(iii) has some other specified interest relating to a specified company or other body or a specified person,

is sufficient disclosure of the nature of the interest in any matter or thing relating to that company or other body or to that person which may arise after the date of the disclosure.

(e) The committee must cause particulars of any disclosure made under By-Law 43(a) to be recorded and declared by the member or authorised person in writing on an actual or potential conflict of interest declaration form.

(f) The chairman of the committee must make a determination in relation to the disclosure under By-Law 43(a) of an actual or potential conflict of interest. Among other things, the chairman may determine that the member or person must not participate in the meeting when the matter is being considered or that the member or person must not be present while the matter is being considered at the meeting or that the person may participate fully in the meeting when the matter is being considered.

(g) The chairman of the committee must advise the Chief Executive Officer of any actual or potential conflict of interest disclosure, and whether the person who made the disclosure participated in the matter to which the disclosure related.

(h) For the purposes of this By-Law 43 the fact that a member of a Credentialing Committee is a member of a particular discipline will not be regarded as an actual or potential conflict of interest, if that committee member participates in the Accreditation process of a Practitioner in the same discipline.

44. RESEARCH

Research involving human subjects that is proposed to be conducted in or at a Facility is only permitted if:

(a) the Scope of Clinical Practice of any Accredited Practitioner to be involved in the research includes clinical activity of the kind proposed in the research;

(b) the Facility is satisfied that appropriate insurance cover and indemnity arrangements with any sponsor, any involved Accredited Practitioner and other relevant party are in place;

(c) the research is required under the National Statement and has been reviewed and approved by an appropriately constituted human research ethics committee acting in compliance with the National Statement and the research is conducted in accordance with the terms of that approval;

(d) approval for the conduct of the research has been obtained from the Facility; and

(e) the research complies with the Code of Conduct and the Code of Ethical Standards.

45. NEW CLINICAL SERVICES, PROCEDURES OR OTHER INTERVENTIONS

(a) An Accredited Practitioner who proposes to perform a New Clinical Service, Procedure or Other Intervention must apply to the Executive Officer for approval.

(b) The Executive Officer must consult with the Executive Director of Medical Services and refer the application to the Chief Executive Officer and the Credentialing Committee.

(c) The Executive Director of Medical Services and Credentialing Committee must advise the Chief Executive Officer:

(i) whether, and under what conditions, the New Clinical Service, Procedure or Other Intervention could be introduced safely to the Facility, with reference to the Facility's Needs and Capabilities; and

(ii) whether the New Clinical Service, Procedure or Other Intervention is consistent with the Accredited Practitioner's Scope of Clinical Practice.

(d) The Chief Executive Officer may request the Executive Director of Medical Services seek additional advice about the financial, operational or clinical implications of the introduction of the New Clinical Service, Procedure or Other Intervention before making a recommendation to the Board.

(e) The Board must decide whether to permit the introduction of a New Clinical Service, Procedure or Other Intervention.

(f) Before approving the introduction of a New Clinical Service, Procedure or Other Intervention the Board must:

(i) be satisfied that the New Clinical Service, Procedure or Other Intervention is consistent with the capability, recurrent operating plan and long-term strategic directions of the Facility;

(ii) where the New Clinical Service, Procedure or Other Intervention involves human research, be satisfied that the requirements of By-Law 44have been met;

(iii) be satisfied that the appropriate indemnity and insurance arrangements are in place; and

(iv) notify the Credentialing Committee of the decision.

46. CONFIDENTIALITY

(a) Accredited Practitioners will manage all matters relating to the confidentiality information in compliance with the Facility's relevant policy or policies, the 'Australian 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 Facility in breach of these obligations. Subject to By-Law 46(c), Accredited Practitioners must, while Accredited and when they cease to be Accredited, keep confidential the following information:

(i) business information concerning the Operator;

(ii) the proceedings for the Accreditation of the Practitioner; and

(iii) information concerning any Patient or staff of a Facility.

(b) Accredited Practitioners will comply with the various legislation governing the collection, handling, storage and disclosure of health information. Subject to By-Law 46(c), all information made available to or disclosed in relation to a committee or sub- committee of a Facility or the Operator must be kept confidential unless the information is of a general kind and disclosure outside the committee or sub-committee is specifically authorised by the committee or sub- committee. This includes

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 whilst performing a role in a quality assurance or peer review process will be kept confidential by Accredited Practitioners.

(c) The confidentiality requirements in By-Laws 46(a) and 46(b) do not apply in the following circumstances:

(i) where disclosure is required or specifically authorised by law;

(ii) where use or disclosure of personal information is permitted under the *Privacy Act 1988* (Cth);

(iii) where disclosure is required by a regulatory body in connection with the Practitioner, the Facility or the Operator;

(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 a requirement of these By-Laws.

47. DISPUTES ABOUT THE BY-LAWS

Any dispute or difference which arises as to the meaning or interpretation of these By-Laws or as to the powers of any committee or the validity of proceedings of any meeting will be determined by the Board.

48. MAKING AND AMENDING THE BY-LAWS

The Board may from time to time amend or revoke any of these By-Laws.

Accredited Practitioners will be bound by any amendment or revocation upon receiving notification of same and in this respect notification may be given by electronic means and/or by the Operator posting details of same on its website or intranet.