SUNSHINE PRIVATE DAY SURGERY

BY – LAWS

COMMERCIAL IN CONFIDENCE

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PART A

1 NAME

The name of the Hospital is Sunshine Private Day Surgery.

2 INTERPRETATION

2.1 Definitions

In these By-Laws unless the context otherwise required:

"Act" means the Health Services Act 1988 including the regulations.

"Chief Executive Officer" means the Chief Executive Officer of the Hospital and any person acting in that position.

"Clinical Privileges" in relation to a Visiting Practitioner to the Hospital means the kind and extent of work which the Board of Directors and Medical Advisory Committee determines the Visiting Practitioner is to be allowed to perform at the Hospital.

"Credentialing Form" means the application form approved by the Hospital from time to time to be used for a Medical Practitioner in applying for Clinical Privileges at the Hospital.

"Department" means the Department of Human Services.

"Director of Nursing and Clinical Services" means the director of nursing (howsoever named) of the Hospital and any person acting in that position and exercising the duties of that position.

"General Practitioner" means a Medical Practitioner registered as such in the State and not practicing as a specialist.

"Hospital" means Sunshine Private Day Surgery.

"Medical Advisory Committee" means the Medical Advisory Committee established in accordance with the By-laws.

"Medical Practitioner" means a person licensed to practice medicine in the State.

"Rules" means any rules established by the Board of Directors following input from the Medical Advisory Committee and which shall establish codes of practice or policy for the Hospital.

"Specialist Practitioner" means a Medical Practitioner who has been recognised as a Specialist in their nominated category for the purpose of the Health Insurance Act 1973 (Commonwealth).

"State" means the State of Victoria.

"Visiting Practitioner or Visiting Medical Officer" means a Medical Practitioner appointed as a medical practitioner at the Hospital otherwise than as an employee.

2.2 Interpretation

(a) In these By-Laws words importing the masculine gender shall also include the feminine gender, words importing the singular shall also include the plural and reference to legislation includes any replacement or amended legislation governing the same or similar areas including regulations thereto as may be replaced or gazetted from time to time.

(b) In these By-Laws, where there is use of the title "Chairman" or "Chairperson" the incumbent of that person at the time being may choose to use whichever designation that person so wishes.

(c) Information provided to any committee or person which is provided in confidence shall be regarded as confidential and is not to be disclosed to any third party or beyond the particular forum or purposes for which such information is made available.

(d) Where required by these By-Laws, voting shall be on a simple majority.

(e) Where a person acts in more than one position, that person shall perform the duties of each such position as required by the By-Laws.

(f) If the By-Laws are found to be too generic, the Board will refer to Australian Council for Safety and Quality in Healthcare for appropriate guidance.

3. CHIEF EXECUTIVE OFFICER

The Chief Executive Officer shall be appointed by the Board of Directors.

It shall be the duty of the Chief Executive Officer to advise the Board of Directors of the due observance by the Hospital of the Act and all other statutes, Department instructions and determinations and these By-Laws.

The Chief Executive Officer will:

(a) be the senior officer of the Hospital to whom all staff will be responsible;
(b) advise the Board of Directors of matters relating to the operational and commercial management of the hospital.
(c) will be a member of all committees directly related to the management of the Hospital and will be an ex officio on all other committees.

4. DIRECTOR OF NURSING AND CLINICAL SERVICES

The Director of Nursing and Clinical Services shall be responsible to the Chief Executive Officer. The Director of Nursing shall be responsible:

(a) for ensuring the suitable standards are maintained to provide a satisfactory and safe environment for both patients and staff;
(b) for advising the Chief Executive Officer on matters of nursing policy;

(c) for ensuring that nursing staff are provided at a level to maintain a sure and safe optimum level of patient care;
(d) for ensuring compliance with the relevant statutory requirements;
(e) for co-operating in the planning of additional facilities and services; and
(f) ensuring availability at all times either personally or by the delegation of authority to meet any emergency or contingency that may arise;
(g) be responsible for the employment of all clinical staff;
(h) be a spokesperson and channel for communication to Visiting Medical Officers and for the hospital.

5. HOSPITAL COMMITTEES

The Chief Executive Officer shall establish a committee or committees to assist in the management and operations of the Hospital. The Chief Executive Officer shall:

(a) Determine the membership of any hospital committee;

(b) Determine the terms of reference of any committee;

(c) Determine the quorum and rights of attendance at any committee;

(d) Oversee any committee voting with approval of Directors;

(e) Determine minimum meeting requirements; and

(f) Determine any other matters pertaining to the appropriate operation or reporting of the committee.

6. BOARD OF DIRECTORS

The Board of Directors shall consist of:

(a) The owner's of Sunshine Private Day Surgery

(b) Any external delegate or consultant as requested by / or at the discretion of the owners.

PART B

7. MEDICAL ADVISORY COMMITTEE

7.1 Composition:

(a) The Medical Advisory Committee shall comprise the Medical Director, and invited Visiting Medical Officers across a range of disciplines as agreed between the Medical Director and Chief Executive Officer. The aim of members being across different disciplines ensures that no one specialty is biased during meetings and any decision making processes. The Ex-Officio Members of the Medical Advisory Committee are the Chief Executive Officer and Director of Nursing.

(b) The Medical Advisory Committee may co-opt other persons from time to time. Such persons shall be ex-officio.

(c) The Medical Director shall attend all meetings of the Medical Advisory Committee and act as the Chairman to that Committee.

(d) Except where otherwise provided removal of a member may be initiated by the Medical Advisory Committee acting on its own recommendation. Removal may be based upon failure to perform the duties of the position held as described in these By-Laws.

7.2 Functions of the Medical Advisory Committee

The Medical Advisory Committee will:

(a) Review any duly completed Credentialing Form and satisfy itself as to the professional capabilities and knowledge, current fitness and confidence held in the applicant and make recommendations thereon to the Board of Directors through communication with the Chief Executive Officer or directly;

(b) provide, if so requested by the Board of Directors, written advice and, where appropriate, making recommendations with reasons to the Board of Directors concerning the Clinical Privileges that should be allowed to Visiting Practitioners including the confidence of the Medical Advisory Committee in such an appointment;

(c) Monitor the overall quality, effectiveness, appropriateness and utilisation of services rendered to all patients in the hospital;

(d) assist in identifying health needs' of the community and advise / make recommendation to the Chief Executive Officer on appropriate services which may be required to meet these needs;

(e) Advise the Board of Directors via the Chief Executive Officer on the acquisition, operation and utilisation of the Hospital's facilities and equipment for the treatment, diagnosis and care of patients;

(f) Make recommendations to the Hospital to provide continuing education responsive to the needs of the staff & Visiting Practitioners;

(g) Advise the Board of Directors via the Chief Executive Officer on such other matters as may be relevant to the proper and efficient functioning of the medical and other clinical services provided by the Hospital;

(h) Be the formal organisation structure through which Clinical Governance and the collective views of Visiting Practitioners shall be formulated and communicated;

7.3 Officers of the Medical Advisory Committee

The officers of the Medical Advisory Committee shall be:

(a) the Chairperson; and

(b) invited Visiting Medical Officers (VMO's) across a range of disciplines representing the hospital's services.

7.4 Duties of Officers

(a) The Chairperson & members shall:

(i) In conjunction with the Chief Executive Officer shall be responsible for enforcement of By-Laws and rules;

(ii) Be responsible in consultation with the Chief Executive Officer for the agenda of all meetings of the Medical Advisory Committee. The Chairperson shall preside at such meetings;

(iii) Provide for effective communication and representation of the opinions, policies, reports, concerns and needs, of the Accredited Visiting Practitioners to the Hospital;

(iv) Facilitate the Medical Advisory Committee reviewing and ratifying medical practice policies or rules of the Hospital as they affect Accredited Visiting Practitioners.

7.5 Quorum and Procedure of Medical Advisory Committee

Three members, one of whom must be the Medical Director, shall constitute a quorum of the Committee and no business shall be transacted unless a quorum is present within half an hour of the time appointed for the meeting.

Seven days notice in writing shall be given to each member by the Chief Executive Officer for every ordinary meeting. In case of a meeting requested specially by the Chief Executive Officer each member shall be given such notice as the Chief Executive Officer may direct. Minutes shall be kept of the proceedings of all meetings by the Chief Executive Officer or their delegate and no business

shall be transacted until the minutes of the previous meeting have been confirmed or otherwise disposed of. No discussion of the previous minutes shall be permitted except as to their accuracy, otherwise added to a new agenda.

Office bearers shall be elected by the Medical Advisory Committee at the first meeting. All questions arising at any meeting shall be decided by a majority of the votes of the members present. Each member shall have one vote. The Chairperson at any meeting shall have a deliberate vote.

The Medical Advisory Committee shall have the power to co-opt any person in considering any matters before it. The Medical Advisory Committee shall have the power to refer any matter whatsoever to any of its sub-committees, if incepted.

A permanent file of the minutes of each meeting shall be maintained by the Chief Executive Officer or delegate.

8. TERMS OF OFFICE

Subject to being otherwise qualified, a member of the Medical Advisory Committee nominated by the Medical Director or Board of Directors shall be eligible to hold office while they are fulfilling their responsibilities.

In the event of a vacancy in a position on the Medical Advisory Committee the Medical Advisory Committee in conjunction with the Chief Executive Officer shall appoint a suitable practitioner to fill that vacancy to the end of the term of appointment of the practitioner vacating that position (if applicable).

PART C - CREDENTIALING AND CLINICAL PRIVILEGES

9. Purpose

The purpose of these guidelines is to provide a framework that can be used by Sunshine Private Day Surgery to establish an appropriate process for the initial granting of clinical privileges for all health care professionals and the ongoing re-validation and review of these clinical privileges, and shall be in accordance with 'Department of Health' guidelines.

The need for national multidisciplinary competency based credentialing and privileging processes arises from a growing public awareness of the need for institutions to fulfil their mandate of protection of public health, safety and welfare and the desire of organisations to ensure quality care.

The aim of such a process is to ensure that health care professionals have an acceptable level of knowledge, skills, attitudes and competence consistent with standards established by their registering professional body (or equivalent) and are practising safely. The process will also consider

performance and reflect on the constraints and support imposed by the available resources, including staff, equipment and the physical resources available within the health care facility.

Health care professionals will be required to provide evidence of their qualifications including registration and/or equivalent training, experience and current competence in the delivery of professional health care services for which clinical privileges are requested. They will also be requested to present evidence of current professional indemnity insurance.

10. Definitions

Appointment

is the formal process of selecting a preferred candidate from among the competing applicants and setting the terms and conditions of appointment, consistent with relevant industrial awards or other determinants. Consideration should be given at the time of appointment to the assessment of credentials and delineation of clinical privileges for the successful applicant in line with needs and resources of the facility as determined by the levels of service provided by the facility. The process is required to comply with guidelines designed to ensure fairness and equity.

Competence

is the application of knowledge and skills in interpersonal relations, decision making and performance consistent with the professional's practice role.

Credentials

represent the formal qualifications, training, experience and clinical competence of the health care professional. They are evidenced by documentation such as university degrees, fellowships/memberships of professional collages or associations, registration by professional bodies, certificates of service, certificates of completion of specific courses, periods of verifiable formal instruction or supervised training, validated competence, information contained in confidential professional referee reports and professional indemnity history and status.

Credentialing

is the formal process of assessing a professional health care professional's credentials in relation to that professional role within a specific facility.

Clinical Privileges

result from a process in which the Governing Body or its delegate grants a health care professional the authority to provide health care services within defined limits in a health care facility. They represent the range and scope of clinical responsibility that a professional may exercise in the facility. Recommendations are made to the Governing Body following the determination of what a health care professional can or cannot do in a facility.

Governing Body

refers to the body or its delegate who has ultimate responsibility for the health care facility.

Health Care Professional

is a health worker eligible for registration with a State or Territory professional body or complies with the requirements of a professional body where registration is not a requirement to practise. All health care professionals working in a facility should hold current registration or its equivalent.

Performance

describes how the output of a process conforms to requirements and expectations and suggests how well an individual, process or team is operating.

11. General Principles

The Medical Advisory Committee (MAC) has the responsibility to ensure the competency and facilitate the performance of all health care professionals practicing within its facilities. All professional health care appointees should have their credentials assessed prior to the selection/appointment process. This will ensure only those applicants who meet the selection criteria and who have the relevant credentials will be allowed to practice at Sunshine Private Day Surgery.

The appointment process should ensure any appointee has the relevant credentials to enable privileges to be granted consistent with the clinical needs of the service to which the appointment relates.

The process of assessing credentials and delineating clinical privileges is undertaken by professional peers who form the MAC. The committee reviews the credentials having regards to the needs and resources of the health care facility in recommending privileges to be granted by the Medical Advisory Committee.

All health care professionals will have their credentials and clinical privileges reviewed at regular intervals throughout the period of their engagement with Sunshine Private Day Surgery.

Information in relation to the credentials and clinical privileges process will be recorded and stored within the facility.

The MAC will have systems in place for the early identification and management of compromised performance including that related to incompetent and impaired practitioners (see Review of Clinical Privileges).

All processes must be underpinned by the principles of natural justice given the significance of this process to professional practice.

12. Committees

12.1 Credentialing and Privileging

The MAC has the responsibility of ensuring that all appointees/health care professionals have the necessary credentials (as per **"Credentialing and scope of clinical practice July 2018"**) to fulfil the responsibilities outlined in their application before permanent appointment. They will assess the credentials of the individual in the context of the role of the professional in the organisation and recommend to the extent of clinical privileges to be granted to the individual. They are also responsible for the ongoing review of clinical privileges of all appointed health care professionals.

Members of committees will ensure that recommendations are based on adequate knowledge of the requirements of the position and are free from bias in relation to any applicant.

Membership

Such committees are peer review committees and as such should be predominantly comprised of representatives of the profession of the health care professional being credentialed, but could also include members of related professions. When a new speciality is being considered, appropriately experienced Medical Officers may be co-opted to review their application and provide recommendation.

13. Credentialing Process

General Principles

(a) Merit is to form the basis of all phases of the process.
(b) Criteria will reflect both the needs and resources of the facility and the credentials of the applicants.
(c) Criteria will assure the Governing Body that patients will receive safe high quality care.
(d) Criteria should be uniformly applied to all applicants.
(e) Additional information will be sought from referees.
(f) Applicants should be given the right to respond to criticisms and to a potentially negative outcome before the committee finalises its decision.
(g) Applicants will be notified promptly if the committee requires clarification of submitted material, or requires additional information.

Specific Criteria

(a) Health Care facility capability (within licence parameters)
(b) Level of service provision
(c) Staffing
(d) Equipment available
(e) Availability of necessary support services
(f) Limitations or restrictions of the facility
(g) Needs and requirement of the facility

Applicant – General criteria

Criteria must be related to professional competence and also include personal behaviour criteria relevant to the position.

Where available, criteria established by the relevant clinical college or professional body should be considered. Current credentialing application forms are based on DHHS template. No applicant is to be denied privileges on the basis of any elements of discrimination (such as sex, race, age, colour, creed or national origin) prohibited in relevant legislation, and the terms of any applicable discrimination legislation should be met. Peer recommendations are to be taken into account but objective support for opinions should be sought.

Applicant – Specific criteria

The committee shall review documentary or other evidence provided by the applicant which demonstrates the following:

(a) Eligibility for professional registration held and current entitlement to practice.
(b) Qualifications and training including undergraduate, postgraduate and special training with respect to privileges requested.
(c) Clinical experience and competence in the field of expertise in which privileges are sought.
(d) That the applicant has subjected and will continue to subject the results of clinical work to quality assurance mechanisms including clinical audit and peer review processes.
(e) Commitment to past and continuing professional education.
(f) Satisfactory professional referee reports including peer comments.
(g) Acceptable and safe practice as evidenced by personal history of complaints, professional body investigations, indemnity and legal records.

Highly desirable key competencies include:

(a) Clinical expertise
(b) Communication skills - patient/families/communities/health care team.
(c) Collaboration skills - cost effective and efficient resource utilisation.
(d) Advocacy skills - patient and professional.
(e) Academic and/or research skills - continuing education aimed at the attainment of best practice models and practices.
(f) Professional integrity.

14. Duration of Clinical Privileges

Clinical privileges shall be granted for a specific period of time, every three (3) The MAC may make recommendation as to any limitation on the duration of clinical privileges if appropriate.

14.1 Probationary Period

The MAC may recommend a probationary period to be served by an individual with respect to clinical privileges. The MAC will determine the purpose of the probationary period, training requirements and method of evaluation at the end of the probationary period, such as following a period of skill development.

14.2 Temporary Privileges (Locums and Short Term Contracts)

Temporary privileges for short-term appointees, such as locums, may be granted without recourse to the full committee. This power shall be delegated to the Chief Executive Officer/Director of Nursing, in consultation with the Medical Director and with ratification of such an appointment at the next meeting of the MAC.

15. Review of Clinical Privileges

Clinical privileges will be reviewed as per **"Credentialing and scope of clinical practice July 2018_0"** for:

1. Initial Appointment
2. Re-credentialing (every three years)
3. Urgent / Temporary credentialing, as granted by the Medical Director or Chief Executive Officer.

NB: Annual credentialing is the responsibility of the CEO/DON who will report to the Committee by exception if there are any issues identified.

Clinical privileges will be also reviewed:

1. At the end of any specified probationary period.
2. At the request of the Medical Director, Chief Executive Officer or the individual practitioner to whom the privileges apply.
3. As the result of significant consumer complaint or a significant complaint from another health practitioner.

In order for the MAC to make meaningful recommendations on clinical privileges, the following information will be made available to the Committee as required:

1. Application form with supporting documents as required by DHHS, Victoria
2. Records of training and experience gained since the last review, including specialist college requirements
3. Registration status, including any conditions of registration or annual practising certificate
4. Current Indemnity Insurance
5. Any adverse professional record
6. Clinical activity, including volumes and outcomes
7. Other relevant information, such as complaints, patient satisfaction records
8. Current clinical privileges and future aspirations

16. Appeals

16.1 General Principles

The appeal process will allow review of any adverse decision and provide an opportunity for any new information to be considered.

16.2 Process

A practitioner whose request for privileges has been denied, withheld or granted in a different form to that requested has the right to appeal against the decision.
The suggested procedure will be as follows:

1. Appeals shall be made to the Board of Directors within 28 days of receipt of notification that clinical privileges have not been granted.
2. Sufficient details of proceedings be fully minuted so that the rationale for decision making can clearly be followed. Each party shall be given the opportunity to speak seeking clarification and identification of the issues. Every opportunity should be taken to seek options for resolution. The aim of the process is to clearly identify the issues and arrive at a solution that is acceptable to all parties.
3. The MAC shall re-consider its decision within 28 days of receipt of the appeal. If the re-considered decision is favourable to the applicant an offer of altered privileges shall be made by the Chief Executive Officer.
4. If the re-considered decision is not acceptable to the applicant, then that individual may discontinue the appeal.

17. Termination of Clinical Privileges

Clinical privileges will be terminated immediately if the practitioner ceases to be legally entitled to practice, or failure to provide evidence of current professional indemnity insurance.

Clinical privileges may also be terminated if the appointment of the practitioner is terminated by the Governing Body or under conditions as determined by the Governing Body.

18. Notification of attaining of Clinical Privileges

Where a practitioners' requests for clinical privileges has been successful, the applicant will be notified in writing by the Chief Executive Officer within two (2) weeks of the relevant Medical Advisory Committee meeting.