CENTAURUS HEALTHCARE

Hospital By-Laws

Effective from: 1 Dec 2023

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The By-Laws are to be used by the Centaurus Hospital Board (the "Board") and all Centaurus Healthcare Private Hospitals to determine the clinical governance requirements with respect to Accredited Practitioners.

1. Foreword

1. This document sets out the By-Laws that are to be adopted by Centaurus Healthcare
2. The By-Laws are to be used by the Centaurus Healthcare Board (the "Board") and Centaurus Private day Hospitals to determine the clinical governance requirements with respect to Accredited Practitioners.
3. These By-Laws apply to all CH Hospitals.
4. These By-Laws must be read in conjunction with Centaurus healthcare Private Hospitals, policies, procedures and appendices adopted by the Board and Centaurus Private Hospitals.
5. The Board has the sole authority to make and amend these By-Laws.
6. For the composition of Committees, membership constitution, method of selection of appointees, term of Appointment, review of Scope of Clinical Practice, frequency of meeting and quorum of Committees refer to the individual committee's Terms of Reference for Centaurus Healthcare (CH) Private Hospitals
7. The composition of each Committee will reflect Centaurus Healthcare organisational requirements, organisational capacity and organisational need for the clinical services provided.
8. Where Centaurus health care Chief Executive Officer (CEO) has delegated their authority to a Delegated Authority in respect of any power under a particular By-Law, a reference to the Chief Executive Officer in that By-Law will also include that Delegated Authority.

2. Preamble

The By-Laws mandate the Accreditation, Credentialing, Re-accreditation and process for defining and amending the Scope of Clinical Practice for Medical Practitioners, providing services to their patients at Centaurus Healthcare, private day Hospitals

The purpose of this process is to assess the training, experience, competence, judgement, professional capabilities and knowledge, fitness and character of a Medical Practitioner who holds Accreditation or seeks Accreditation at Centaurus Healthcare Hospitals. Relevantly, there is the ability to amend, suspend or terminate a Medical Practitioner's, Health Professional's Accreditation or Scope of Clinical Practice in the interest of patient safety, the needs and capacity of the Hospital or if the Accredited Practitioner displays conduct inconsistent with Centaurus Healthcare Private Hospital's mission, vision or values.

Credentialing and defining the Scope of Clinical Practice are governance responsibilities of the Medical advisory Committee, Board, CEO and may be delegated as appropriate. The Credentialing, Re- accreditation and the process for defining and amending Scope of Clinical Practice is a non-punitive process. These processes, as set out in these By-Laws, are fair and transparent.

Centaurus Healthcare policies, procedures and practices reflect and are consistent with the expectation of the communities within which it is located. Those who obtain Accreditation as an Accredited Practitioner agree to respect and observe those principles embodied in the following (as amended from time to time):

- Mission, Vision and values of Centaurus Healthcare
- Code of Conduct of Centaurus healthcare
- Codes of Conduct articulated by relevant registration authorities
- These By-Laws
- Applicable policies, annexures and procedures
- Applicable State and Commonwealth policies and legislative requirements

3. Overview

Centaurus Healthcare and Direct Endoscopy aims to create an environment where their patients are provided exceptional care in a safe environment. In order for our organisation to achieve this, our company aims to create a culture where clinicians and employees feel supported and have the opportunity to contribute to the overall team in a positive manner. Centaurus Healthcare and Direct Endoscopy encourages our clinicians and day hospital staff to succeed and to embrace a culture based on continual improvement to ensure our organisation provides exceptional patient care

The By-laws define the relationship and obligations between Centaurus Healthcare/Direct Endoscopy and its Accredited Medical Officers. This document sets out certain terms and conditions upon which Medical Officers may apply to be Accredited within the defined Scope of Practice which is the basis upon which a successful applicant can treat Patients at the Facility, and the terms and conditions for continued Accreditation.

Every applicant for Accreditation will be given a copy of the By-Laws at the time of making an application. It is expected that the By-laws are read in their entirety by the applicant as part of the application process.

Dr David Badov
Medical Director
Centaurus Healthcare

4. By-Laws

4.1. Function of By-Laws

a) Day to day managerial responsibility of CH hospitals is delegated by the Board to the CEO. The By-Laws provide direction from the Board to the CEO in relation to exercise of certain aspects of their managerial responsibility.
b) Medical care at CH hospitals is provided by Accredited Practitioners who have been granted access to the Hospital and the use of the Hospital facilities. The By- Laws define the relationship and obligations CH and its Accredited Practitioners.
c) CH aims to maintain a high standard of patient care and to continuously improve the safety and quality of its Hospital services. The By-Laws, schedules and annexures implement measures aimed at maintenance and improvements in safety and quality.
d) CH is subject to numerous legislation and standards. The By-Laws assist in compliance with certain aspects of this regulation.

4.2. By-Laws apply to Centaurus Healthcare Hospitals

This document sets out the By-Laws that apply to the Hospital and any other services which the Board has determined they will apply.

4.3. Inconsistencies with legislation

Where there is any inconsistency between these By-Laws and any Act applicable to CH Hospitals, to the extent of such inconsistency the Act will prevail and apply.

4.4. Modification of By-Laws

From time to time the By-Laws may be modified by the Board.

a) Unless otherwise specified by the Board, changes take effect from the date the change is approved by the Board and such changes shall apply to all Accredited Practitioners from that date.
b) If the modified By-Laws are to have retrospective effect, this must be specifically stated by the Board, as well as the time that the modifications shall take retrospective effect. The modified By-Laws apply to all Accredited Practitioners, including those Accredited Practitioners accredited prior to the modification of the By-Laws.
c) The Board or CEO may approve the annexures that accompany these By-Laws, and amendments that may be made from time to time, and the appendices once approved by the Board or CEO will form part of the By-Laws.
d) The Board or CEO may approve terms of reference, (as above) policies, procedures and audit tools that are created pursuant to these By-Laws or to provide greater detail and guidance in relation to implementation of aspects of these By-Laws. These may include but are not limited to Accreditation, Credentialing and Organisational Capabilities and the further criteria and requirements will be incorporated as criteria and requirements of these By-Laws.

5. Interpretation

5.1. Definitions

In these By-Laws, unless the context otherwise requires:

Accreditation means the authorisation in writing conferred on a person by the CEO, and the acceptance in writing by such person, to deliver medical, surgical, dental or other health services to patients at the Facility in accordance with:

- the specified Accreditation Classification where applicable and Scope of Clinical Practice;
- any specified Conditions;
- the Code of Conduct;
- the policies and procedures at the Hospital; and
- these By-Laws.

Accreditation and credentialing committee mean the committee Medical Advisory Committee for the purpose of considering:

a) applications for Accreditation or re-accreditation by Medical Practitioners,
b) the organisational Needs and organisational Capabilities of the Hospital, including

New Clinical Services, Procedures or other Inventions;

c) Scope of Clinical Practice for Accredited Practitioners and Accredited Professionals; and disputes, complaints and reviews in relation to items (a) to (c).

Accredited Practitioner means a Medical Practitioner who has Accreditation at CH private Hospitals in accordance with a specified Accreditation Classification and Scope of Clinical Practice.

Act means all relevant legislation applicable to and governing:

a) the Facility and its operation;
b) the support services, staff profile, minimum standards and other requirements to be met in the hospital; and
c) the health services provided by, and the conduct of, the Accredited Practitioner.

AHPRA means the Australian Health Practitioner Regulation Agency established under the Health Practitioner Regulation National Law Act 2009 (as in force in each State and Territory), which came into effect on 1 July 2010.

Application Form means the form approved by the hospital from time to time for use by a Medical Practitioner, to apply for Accreditation at CH hospitals as per Safer Care Victorian Guidelines

Board means the Board of CH hospitals

Board is a committee established to ensure systems are in place and are being monitored to ensure:

a) all clinical risks are being appropriately managed;
b) safe, quality clinical care is being provided to patients, clients; and
c) a culture of clinical quality improvement is being fostered and is inherent.

By-Laws means these By-Laws, including any Schedules, as amended from time to time.

Chief Executive Officer (CEO) means the Chief Executive of CH private Hospitals

Code of Conduct means the relevant code of conduct of CH Private Hospitals.

The Medical Advisory Committee was **e**stablished by the CH private Day Hospitals Board in accordance with these By-Laws including but not limited to perform the following functions:

a) Credentialing and Accreditation in accordance with these By-Laws;
b) Defining the Scope of Clinical Practice in accordance with these By-Laws;
c) Appeals in accordance with these By-Laws;
d) Patient care and clinical outcomes; and
e) Clinical services

Condition means as applicable with respect to an Accredited Practitioner or an Accredited Professional: any condition imposed by a Regulatory Authority including the National Practitioner Board under the Health Practitioner Regulation National Law Act 2009; and any condition imposed pursuant to the processes set out in these By-laws.

Credentialing means the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of a Medical Practitioner, an Accredited Practitioner or an Accredited Professional for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific Hospital environments. Credentialing involves obtaining evidence contained in verified documents to delineate the theoretical range of services, which an Accredited Practitioner is competent to perform.

Credentials means the qualifications, professional training, clinical experience, current registration and status, indemnity insurance, training and experience in leadership, research, education, communication and teamwork that contribute to the competence, performance and professional suitability to provide safe, high quality healthcare services at the Hospital.

Current Fitness means the current fitness required of an Accredited Practitioner (or Accredited Professional) to carry out the Scope of Clinical Practice sought or currently held. An individual does not have current fitness if that person suffers from any physical or mental impairment, disability, condition, or disorder which detrimentally affects, or is likely (in the CEO's reasonable opinion) to detrimentally affect the individual's physical or mental capacity to practice medicine.

Executive ***Director of Clinical Services (EDON)*** means the Executive Director of Nursing (or Director of Nursing, however titled) of CH Hospitals

Facility (or Hospital) means a Hospital or Day Procedure Centre conducted by CH.

Health Department means the Department of Government with the responsibility for health in the State of Victoria.

MAC means Medical Advisory Committee appointed by Centaurus Healthcare for the purpose of advising the Hospital on, the Accreditation and Re-accreditation of Medical Practitioners, Practitioners at CH Hospitals and various other matters relating to the safety and quality of services at the Facility as defined in the relevant Victoria Private Health Facility legislation or regulations.

Medical Practitioner means a person registered as a medical practitioner by the Medical Board of Australia governed by AHPRA pursuant to the Health Practitioner Regulation National Law Act 2009 as in force in each State and Territory.

National Law means the Health Practitioner Regulation National Law Act (2009) as in force in each State and Territory from time to time.

New Clinical Services, Procedures, or Other Interventions means (including medical or surgical procedures, and the use of prostheses and implantable devices or diagnostic procedures) that are considered by a reasonable body of medical opinion to be significantly different from existing clinical practice. It includes a procedure that has not been performed at Ch Hospitals as well as variations to an existing procedure or treatment where a new device or item of equipment is introduced.

Notifiable Conduct means conduct as defined in the Health Practitioner Regulation National Law Act 2009, as in force in each State and Territory, and amended from time to time, in relation to a registered health practitioner, and currently means the practitioner has:

a) practiced the practitioner's profession while intoxicated by alcohol or drugs; or
b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or
c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or
d) placed the public at risk of harm because the practitioner has practiced the profession in a way that constitutes a significant departure from accepted professional standards.

Organisational Capabilities means CH Hospital's ability to provide facilities, services and clinical and non-clinical support necessary for the provision of safe, high quality clinical services, procedures or other interventions and associated allied health services in compliance with the relevant Private Health Facility Act in force in the State or Territory in which CH Hospitals is located and otherwise as required to satisfy the clinical services capability framework of the Hospital.

Organisational Need means the extent to which the Facility elects to provide a specific clinical service, procedure or other intervention or associated allied health service in order to provide a balanced mix of safe, high quality health care services that meet patient and community need and expectation. This will include consideration of the strategic, operational and business plans, goals and objectives of CH Private Hospitals including the need for and profitability of various specialty services at specific Facilities.

Professional Indemnity Insurance means the insurance of an Accredited Practitioner or Accredited Professional taken out in accordance with By-Law 13.4.

Professional Misconduct has the same meaning prescribed to that term and the term "Unsatisfactory Professional Conduct" in the Health Practitioner Regulation National Law Act 2009 or associated Act as in force in each State and Territory and includes (but is not limited to):

a) unprofessional conduct by the practitioner that amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and
b) more than one instance of unprofessional conduct that, when considered together, amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and
c) conduct of the practitioner, whether occurring in connection with the practice of the health practitioner's profession or not, that is inconsistent with the practitioner being a fit and proper person to hold registration in the profession.

Re-accreditation means the formal process used to re-confirm the qualifications, experience and professional standing (including history of and current status with respect to professional registration, disciplinary actions, indemnity insurance and criminal record) of Accredited Practitioners (or Accredited Professionals) for the purpose of forming a view about their ongoing competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments.

Regulatory Authority means any government or any governmental, semi-governmental, administrative, fiscal or judicial body, department, commission authority, tribunal, registration authority, agency or entity including for the avoidance of doubt AHPRA.

Reportable Conduct means any serious offence against children, as envisaged by applicable child protection legislation in any jurisdiction, including but not limited to neglect, assault or sexual offence committed against, with or in the presence of a child (including child pornography offences).

Scope of Clinical Practice means the process following on from Credentialing and involves delineating the extent of an Accredited Practitioner's (or Accredited Professional's) clinical practice within CH Hospital's based on the individual's Credentials, competence, performance and professional suitability and the Organisational Need and Organisational Capabilities of the Facility to support the Accredited Practitioner's (or Accredited Professional's) Scope of Clinical Practice.

Temporary Appointment means an appointment of an Accredited Practitioner (or Accredited Professional) for a specified period of 90 days only

Unprofessional Conduct or Unsatisfactory Professional Conduct has the same meaning prescribed to those terms in the Health Practitioner Regulation National Law Act 2009 as in force in each State and Territory.

5.2. General Information

Rules for Interpreting these By-Laws

a) The following rules apply in interpreting these By-Laws, except where the context makes it clear that the rule is not intended to apply:
   i) Headings are for convenience only and do not affect interpretation.
   ii) A reference to legislation (including subordinate legislation) is to that legislation as amended, re-enacted or replaced, and includes any subordinate legislation issued under it.
   iii) A reference to a document or agreement, or a provision of a document or agreement, is to that document, agreement or provision as amended, supplemented, replaced or novated.
   iv) A singular word includes the plural, and vice versa.
   v) A word which suggests one gender includes the other gender.
   vi) If a word is defined, another part of speech has a corresponding meaning.
   vii) If an example is given of something (including a right, obligation or concept) such as by saying it includes something else, the example does not limit the scope of that thing.
   viii) A reference to "Accredited Practitioner" in these By-Laws includes "Accredited Professional", as the context requires.

b) Titles
    i) In these By-Laws, where there is use of the title "chairperson" the incumbent of that position for the time being may choose to use whichever designation that person so wishes.
c) Quorum
    i) Except where otherwise specified in these By-Laws or where otherwise determined by the CEO, the following quorum requirements will apply:
        (a) where there is an odd number of members of the Committee or group, a majority of the members; or
        (b) where there is an even number of members of the Committee or group, one half of the number of the members plus one.
        (c) Resolutions without meetings
d) A decision may be made by a Committee or group established pursuant to these By- Laws (except that established by By-Law 19) without a meeting if a consent in writing, including electronic means, setting forth such a decision is signed by all the Committee or group members, as the case may be.
e) Meeting by electronic means
    i) A Committee or group established pursuant to these By-Laws (except that established by By-Law 19) may hold any meeting by electronic means whereby participants can be heard and can hear but are not necessarily in the same place. The requirements of these By-Laws will nonetheless apply to such a meeting.
f) Voting
    i) Unless otherwise specified in these By-Laws, voting will be on a simple majority basis and only by those in attendance at the meeting of the relevant Committee or group and there will be no proxy vote.
g) Delegation
    i) Where these By-Laws confers a function or responsibility on the CEO, that function or responsibility may be performed wholly or in part by a Delegated Authority (except where the Board or the context of a By-Law or the delegations applicable to CH Private Hospital requires that function or responsibility to be exercised personally by the CEO).
h) Compensation
    i) Unless there is a jurisdictional provision for compensation of such services, members of Committees or groups established under these By-Laws are not entitled to receive, and will not receive, compensation for any services rendered in their capacities as Committee members.

6. Privacy and Confidentiality

6.1. Privacy

Accredited Practitioners will comply with, and assist the Facility to comply with the Australian Privacy Principles established by the Privacy Act 1988 (Cth) and the various statutes governing the privacy of health information within each State and Territory in Australia (or equivalent laws if the facility is located in another jurisdiction).

6.2. Accredited Practitioners

Subject to By-Law 7.1, every Accredited Practitioner must keep confidential the following information:

a) business information concerning CH or its subsidiaries;

b) information concerning the insurance arrangements of CH or its subsidiaries where applicable;
c) personal, sensitive or health information concerning any patient, clinical practice, quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services and any employee or contractor of CH or its subsidiaries
d) individual contract agreements, business agreement, joint ventures or any other agreement with VMOs which would be considered 'Commercial in Confidence' or 'Confidential'
e) the particulars of these By-laws

6.3. Committees

All information made available to, or disclosed, in the context of a Committee of CH will be kept confidential and be subject to all relevant privacy laws unless the information is of a general kind and disclosure outside the Committee is authorised specifically by the Committee, including the following information:

a) the application for the Accreditation including designation of Scope of Clinical Practice of the Accredited Practitioner; and
b) the application for or consideration of any change to Scope of Clinical Practice of the Accredited Practitioner

6.4. What confidentiality means

The confidentiality requirements of By-Laws 7.1, 7.2 prohibit the recipient of the confidential information from using or disclosing it for any unauthorised purpose, copying it, reproducing it or making it public.

6.5. When confidentiality can be breached

The confidentiality requirements of By-Laws 7.1, 7.2 do not apply in the following circumstances:

a) where disclosure is required or specifically authorised By-Law;
b) where use and/or disclosure of personal information is consistent with By- Law 7.1;
c) where disclosure is required by a Regulatory Authority in connection with the Accredited Practitioner;
d) where the person benefiting from the confidentiality consents to the disclosure or waives the confidentiality; or
e) where disclosure will not breach By-Law 7.1 and is required in order to perform a requirement of these By- Laws or is required to provide clinical care to the patient.

6.6. Privacy and confidentiality obligations continue

The privacy and confidentiality requirements of these By-Laws continue with full force and effect after the Accredited Practitioner ceases to hold Accreditation with CH or its subsidiaries.

6.7. Centaurus Healthcare

Centaurus Healthcare will be entitled to disclose an Accredited Practitioner's confidential information (including personal information and sensitive information as those terms are defined in the Privacy Act 1988 in relation to their Accreditation or any other matters related to these By- laws to other CH Hospital entities.

7. Board Powers and Transitional Arrangements

7.1. Board powers

a) The Board is empowered to make By-Laws, rules, regulations and policies for the operation of Centaurus Healthcare private day surgery facilities as it may deem necessary from time to time.
b) Unless otherwise specified, changes take effect from the time of the resolution by the Board.
c) Any changes under By-Law 8.1(b) take effect from the date the change is approved by the Board and apply to all Accredited Practitioners from that date.

7.2. Transitional arrangements

Accreditation under previous By-Laws is maintained under any new By-Laws approved by the Board.

8. Committees

8.1. Power to establish operational Committees

a) The Board may establish any Committees deemed necessary to comply with any Act or for the effective and compliant conduct of CH.
b) Subject to these By-Laws and any Act, the CEO can determine the membership, powers, authorities and responsibilities that are delegated to a Committee and the administrative rules by which each Committee is to operate.

8.2. Terms of Reference for Committees

Refer to the individual Terms of Reference for Committees.

8.3. Indemnification

The Facility will indemnify the members of each Committee in respect of any actions or

claims made provided the Committee members have:

a) acted in good faith;
b) acted in accordance with their delegated authority; and
c) acted in accordance with any Act governing their conduct.

8.4. Statutory immunity for Committees

a) CH may in specific circumstances seek and be granted declarations under jurisdictional legislation in respect of a Committee at CH Hospital's where the Committee's emphasis is on the quality assurance or review of clinical practice or clinical competence. Such a declaration may, amongst other things, afford statutory immunity or qualified privilege or similar for members of that Committee in the course of carrying out specific aspects of the role and function of that Committee.

8.5. Committee access to the Board

CH will develop a standing agenda item for the Medical Credentialing Committees to discuss and escalate issues of a complex credentialing nature to the CH Hospital Board.

8.6. Chairperson to notify Chief Executive Officer

The Chairperson of the Medical Advisory Committee will:

a) notify the CEO of any disclosure made under this By-Law; and
b) record the disclosure in the minutes of the relevant Committee.

8.7. Determination to effect of matter disclosed

The CEO (in consultation with the Chairperson of the Committee) will make a determination in relation to a disclosure under this By-Law. Such a determination may include (but is not limited to) making a determination that the member or person will not participate in the Committee meeting when the matter is being considered or that the member or person will not be present while the matter is being considered.

8.8. Matters that do not constitute direct or indirect material personal interest

Subject to By-Law 8.8, the fact that a member of any Committee, is a member of a particular clinical discipline will not be regarded as a direct or indirect material personal interest, if that person participates in the Appointment process, the process to consider amendment of the Scope of Clinical Practice, or the suspension or termination of an Accredited Practitioner in the same discipline.

9. Clinical Review Committees

9.1. Objectives

CH will have the following Committees (and any other Committees required by law or as deemed necessary by CH and its Hospitals:

a) Medical Advisory Committee (MAC)
b) Operational Management Meetings (OMM)
c) Quality, risk and Safety Committee (QRSC)
d) Anaesthetic Group Meetings
e) Gastroenterology Craft Group
f) Board meeting

The functions, expectations and Terms of Reference are held separate to these By-Laws and should be referenced in conjunction to the relevant committee meeting

a) The chairperson, or their delegate for this purpose, must record minutes of the formal meetings of the above committees
b) Minutes recorded at formal meetings must be distributed to the members of the Committee in a timely manner.
c) All minutes and actions arising from these formal Meetings are to be forwarded to the CEO, Board, and the Medical Advisory Committee of the Facility.

9.2. Mandatory attendance

a) It is a Condition of Accreditation that if requested:
    i. all Accredited Practitioners must attend and participate in at least one Formal Meeting of the Anaesthetic or Gastroenterological Committee and/or relevant, annually; and
    ii. 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.

10. Appointment of Accredited Practitioners

10.1. Principles

The following principles should be considered and guide the making of decisions in the

Credentialing and Accreditation process:

a) Credentialing and Accreditation are organisational governance responsibilities that are conducted with the primary objective of maintaining and improving the safety and quality of health care services;
b) Processes of Credentialing and Accreditation are complemented by registration requirements and individual professional responsibilities that protect the community;
c) Effective processes of Credentialing and Accreditation benefit patients, communities, health care organisations and health care professionals;
d) Credentialing and Accreditation are essential components of a broader system of organisational management of relationships with health care professionals;
e) Credentialing and Accreditation and any reviews should be a non-punitive process, with the objective of maintaining and improving the safety and quality of health care services;
f) Processes for Credentialing and Accreditation Privileges depend for their effectiveness on strong partnerships between health care organisations and professional colleges, associations and societies;
g) Processes of Credentialing and Accreditation should be fair and transparent, with the By-Laws drafted to accommodate these principles; therefore compliance with the By-Laws and its processes is important.

10.2. Application Form

a) Any Medical Practitioner, who wishes to apply for Accreditation, Re-accreditation or an increase in Scope of Clinical Practice at CH must obtain from the Hospital an Application Form (and any related material, including a copy of these By-Laws) and must complete and submit the Application Form to the CEO.

10.3. Applications for Appointment

A duly completed application form will be considered in accordance with the following process:

a) The CEO will consider the application in the context of the organisational need and organisational capabilities of the Facility and may make any inquiries or consultation relevant to that consideration as they think fit. Following this consideration, the CEO may determine to discontinue with the application process or consider the process as outlined at By-Law 10.3(b) – (n) below. The CEO may liaise with the Accreditation and Credentialing Committee in relation to this stage of enquiry

b) The CEO (after receiving advice from the MAC may define particular additional categories and types of Scope of Clinical Practice or limit the Scope of Clinical Practice being considered, as the individual circumstances may require.

c) The CEO (or their delegate) may contact up to three referees nominated by the Applicant, but for an application to proceed the CEO must receive no less than 2, to request written references and must also check the Applicant's qualifications, Professional Indemnity Insurance and Credentials (including verifying registration and current entitlement to practice). Referees must include a current supervisor at the facility or a supervisor not at

the same facility but currently practicing in the same specialty as the potential appointee.

d) The CEO (or their delegate) may obtain verbal references or verbal confirmation of written references. A verbal reference must be obtained by completing the appropriate template (Appendix 3) for verbal references and all fields must be completed, including the minimum data sets for written reference reports.

e) If a referee declines to provide a written reference, the CEO must record that fact. The CEO may contact the Applicant and request that the Applicant nominate another referee.

f) The CEO may ask for advice on the application from the head of the division(s) or department(s) of the Facility most relevant to the application (where applicable).

g) The CEO will liaise with the MAC during the process of enquiry and review identified in (b) above to (i) below and prepare an application report which includes consideration of and recommendations relating to the application, organisation capabilities, credentials, scope of Clinical Practice, Current fitness, character and applicant integration (Application Report).

h) If the Application Report recommends granting Accreditation, the CEO must provide a copy of the Application Report to the MAC, and an assessment made by that Committee of the Application.

i) The MAC will make recommendations to the CEO as it deems appropriate relating to the Application generally and in particular regarding the Credentials, Current Fitness, requested Scope of Clinical Practice and any Conditions to the Accreditation

j) The MAC Recommendations will then be considered by the CEO prior to making a final determination as to the Accreditation sought by the applicant prior to forwarding to the Board for final ratification.

k) The Board will make a final determination on the application and will have complete discretion to approve or disapprove each application for Accreditation or Re-accreditation after following the provisions set out in By- Laws 10.3(a) to 10.3(l) (where applicable).

l) The CEO must notify each applicant in writing of their decision.

m) Any delineation of approved scope of Clinical Practice for the Applicant must be specifically defined in the letter of Accreditation. Approval is granted by the CEO on behalf of the Board.

n) The term of the Accreditation must not exceed three (3) years from the date of approval or one (1) year in respect of Accredited Practitioners being 80 years of age.

o) On receiving notice of Appointment, the applicant will indicate their acceptance in writing of the Facility By-Laws, rules, regulations and also CH Private Hospital's Visions, Mission, Values and Care Statements.

10.4. Temporary Appointment (including Locum Appointment)

a) The CEO may approve Temporary Appointments and may grant Accreditation to such temporarily appointed Medical Practitioners.
b) An individual seeking Temporary Appointment must submit an Application Form to the CEO along with all required supporting documentation.
c) In considering whether to approve the Temporary Appointment of a Medical Practitioner, the CEO must satisfy the application process set out in By-Law 10.3 and consult with the

head of the division or department most relevant to the applicant's specialty and the MAC chair.

d) Accreditation granted under this By-Law 10.4 will remain in force for a period of up to 90 days from the date of determination by the CEO.
e) Provisional appointment may be granted by the CEO, after initial review of the complete application but only in circumstances where there is a genuine need to expedite the Accreditation to ensure provision of medical services for the benefit of identifiable patients and provided that the CEO continues the final Accreditation process set out in Rule 10.3 in a timely manner.
f) The CEO will notify the Accredited Practitioner in writing.
g) There will be no right of appeal in respect of the cancellation or suspension of Accreditation of a Medical Practitioner, holding a Temporary Appointment or the decision of the CEO in relation to a Temporary Appointment application.

10.5. Urgent Accreditation

a) In accordance with this By-Law 10.5, the CEO or delegate may approve urgent Accreditation to Medical Practitioners, (Urgent Accreditation).
b) In considering whether to approve an Urgent Accreditation, the CEO must at a minimum:
    iii. confirm registration with AHPRA or relevant Regulatory Authority and consider any antecedents identified, including conditions or complaints;
    iv. obtain a verbal reference from one other Accredited Practitioner at the Facility or from a practitioner not at the same Facility but currently practicing in the same specialty as the potential appointee; or from the Medical director/ Chief Medical Officer at the applicants place of current Accreditation;
    v. minimum 100-point verification of identity through inspection of relevant documents (e.g. birth certificate, passport, driver's license with photograph) as adopted by the Australian Government and identified in the 100 points of identification guide.
c) An individual seeking or granted Urgent Accreditation must provide evidence of Professional Indemnity insurance within 24 hours of being granted Urgent Accreditation.
d) Urgent Accreditation granted under this By-Law 10.5 applies only to the specific patient or episode of care for which the Accreditation is sought.
e) The CEO will advise the Accredited Practitioner in writing of the completion of the Urgent Accreditation.
f) Provision of Urgent Accreditation does not grant the Accredited Practitioner the right to Temporary Accreditation.

10.6. Appointments made periodically

a) Unless otherwise determined by the CEO, Accreditation of Medical Practitioners are to be made in accordance with the requirements of the Facility and a periodic cycle determined by the CEO and will be for a period of:
    i. one (1) year;
    ii. three (3) years;
b) The period will be determined by the CEO and shall commence from the date the CEO approves the Accreditation.
c) Where Accreditation is granted and it coincides with the commencement of any periodic cycle referred to in By-Law 10.6(a), the Accreditation will be for the specified period. Where Accreditation is granted after a periodic cycle has commenced, Accreditation will be for the

unexpired portion of that specified period.

d) The periods of up to one year, two years, or three years for the purpose of these By-Laws will begin and conclude in accordance with the sequence customary at the Facility.

10.7. Appointments of Directorships

a) Appointments of Directorships including a Medical Director and or any other directorships are appointed at the discretion of the CEO.
b) Appointments of Directorships can change at any time and are rotational with a maximum duration of three (3) years.
c) The CEO has complete authority to withdraw an appointed Directorship within the three (3) year tenure or at any time. There will be no appeal against such a decision.
d) All appointment of Directorships shall be conducted in consultation with the Board prior to formal ratification.

10.8. Basis of Accreditation

Accreditation does not of itself constitute an employment contract nor does it establish a contractual relationship between the Accredited Practitioner and the Facility or a right of access to the Facility or use of its facilities. It is a condition of accepting Accreditation, and of ongoing Accreditation, that the Accredited Practitioner understands and agrees that:

a) these By-Laws set out processes and procedures available to the Accredited Practitioner with respect to all matters relating to and impacting upon Accreditation;
b) 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; 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 at the Facility for the period of Accreditation;
c) the granting of Accreditation creates no rights or legitimate expectation with respect to access to the Hospital or its resources or facilities;
d) acknowledge the granting of accreditation does not create an employer/employee contractual arrangement giving rise to appeal rights;
e) while CH will generally conduct itself in accordance with the By-Laws, it is not bound to do so and there are no legal consequences for not doing so.

11. Terms and Conditions of Accreditation

11.1. Conditions applicable to all Accredited Practitioners

Approval of Accreditation for a Medical Practitioner, is conditional on the Accredited Practitioner complying with all matters and Conditions set out in this By-Law 11.

11.2. General

Accredited Practitioners must:

a) comply with their authorised Scope of Clinical Practice;
b) comply with the Code of Conduct and any other reasonable directions given or policies adopted by the CEO in relation to standards of behavior to be maintained by Accredited Practitioners;
c) comply with the provisions of the Act, all applicable legislation and general law;
d) comply with their responsibilities under the National Law in regard to mandatory

notification of Notifiable Conduct by another practitioner, where the Accredited Practitioner has formed a reasonable belief that a health practitioner has behaved in a way that constitutes Notifiable Conduct in relation to the practice of their profession or suffers from an impairment that may place the public at substantial risk of harm.

e) comply with these By-Laws and the rules and policies and procedures of the Hospital as modified from time to time;
f) maintain their professional registration with AHPRA (and/or other relevant Regulatory Authority) and furnish annually to the Facility when requested to do so, evidence of registration and advise the CEO immediately of any material changes to the conditions or status of their professional registration (including suspension or termination);
g) attend patients subject to the limits of any Conditions imposed by the CEO; if theatre sessions have been requested by the Accredited Practitioner and allocated, then the Accredited Practitioner must effectively utilise the theatre sessions;
h) observe all requests made by the Facility with regard to their conduct in the Facility and with regard to the provision of services within the Facility;
i) adhere to the generally accepted ethics of medical practice and other health practitioners including the ethical codes and codes of good medical practice of the Medical Board of Australia, CH Hospital employees and patients and the "Good Medical Practice: A Code of Conduct for Doctors in Australia" published by the Medical Board of Australia.
j) adhere to general Conditions of clinical practice applicable at the Facility, including compliance with and assisting the Facility to comply with the National Safety and Quality Health Service Standards (2017) accreditation requirements through a reputable accreditation agency or such other additional accreditation requirements as nominated by CH as well as assisting the Hospital to comply with specific requirements of private health insurers as may be advised by the CEO from time to time during the period of Accreditation;
k) observe the rules and practices of the Facility in relation to the admission, discharge and accommodation of patients;
l) attend and, when reasonably required by the CEO, prepare for and participate in relevant clinical meetings, seminars, lectures and other teaching/training programs organised by the Facility or provide evidence of attendance of these at alternative venues;
m) participate, when requested by the CEO, in Committee meetings, including review of clinical data and outcomes and respond to requests for information regarding statistical outliers, adverse events and cases flagged in incidents, clinical indicator or key performance indicator reporting;
n) seek relevant approvals from the CEO and relevant Committee and, where applicable, the relevant research and ethics Committee in regard to any research, experimental or innovative treatments, including any New Clinical Services, Procedures or Other Inventions
o) not aid or facilitate the provision of medical health care to patients at the Ch Private Hospitals by Medical Practitioners, who are not Accredited Practitioners;
p) not purport to represent CH Private Hospitals or its subsidiaries in any circumstances, including the use of the letterhead of the Hospital, unless with the express written permission of the CEO and/or the Board;
q) subject to the requirement of relevant laws, keep confidential details of all 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;
r) co-operate with and participate in any clinical quality assurance, quality improvement or risk management process, project or activities as required by the Facility and these By-Laws, including assisting in and providing information with respect to adverse events and, system

reviews, including but not limited to Root Cause Analysis (RCA); and

s) where reasonable to do so, participate in open disclosure discussions with patients and families of patients and ensure regular follow up with patients following procedures and/or completion of services to ensure the best possible patient outcome and experience.

11.3. Responsibility for patients

Accredited Practitioners must:

a) obtain full and informed written patient consent prior to a procedure being performed that includes advising the patient that a Surgical Assistant may be present;
b) not admit a patient to a CH Hospital, whom does not meet the admission criteria.
c) admit to the CH Private Hospitals only those patients who, in the opinion of the CEO, can be properly managed in the Facility, including in accordance with the approved clinical services capability attached to Hospital's license (the CEO may notify Accredited Practitioners from time to time of any categories of patients who are considered inappropriate for admission to CH private Hospitals;
d) observe the rules and requirements applicable in the Facility with respect to the admission of patients;
e) accept full responsibility for their patients from admission until discharge
f) work with and as part of the multi-disciplinary health care team, including effective communication – written and verbal, to ensure the best possible care and outcome for Accredited Practitioners' patients, including post treatment follow up care and communication;
g) provide adequate instructions to Facility staff and other Accredited Practitioners to enable them to understand what care the Accredited Practitioner requires to be delivered to their patients and appropriately supervising the care that is provided by the Facility staff and other Accredited Practitioners;
h) note the details of a transfer of care to another Accredited Practitioner on the patient's medical record and communicating the transfer to the Nurse Unit Manager or other responsible nurse staff member;
i) attend their patients properly, and with the utmost care and attention, after considering the requirements of the Facility and Scope of Clinical Practice granted to the Accredited Practitioner;
j) upon request by staff of the Facility, attend to patients under their care for the purposes of the proper care and treatment of those patients;
k) except in an emergency, not give instructions in relation to a patient where another Accredited Practitioner is responsible for the management of that patient without a formal request for consultation from the consulting clinical team;
l) carry out procedures, give advice and recommend treatment within the generally accepted areas of practice applicable to the Accreditation Classification of the Accredited Practitioner and to their Accreditation;
m) be willing, in an emergency or on request by the CEO (or another person authorised by the CEO for this purpose) to assist the staff and other practitioners, where possible and necessary;
n) comply with all infection control procedures of the Facility including appropriate hand hygiene;
o) not treat a member of their immediate family or anyone with whom they have a close personal relationship without the written approval of the CEO (which may be given or withheld at the CEO's absolute discretion).

11.4. Professional Indemnity Insurance

Accredited Practitioners must maintain a level of professional indemnity insurance (including run off/tail insurance where appropriate) consistent with requirements of the relevant Regulatory Authority:

a) which covers all potential liability of the Accredited Practitioner in respect of the Facility and patients;
b) which appropriately reflects and covers the Accredited Practitioner's Scope of Clinical Practice and activities performed at the Facility; and
c) that is on terms and conditions acceptable to the Facility.

11.5. Annual disclosure

Accredited Practitioners must furnish annually to CH evidence of:

a) appropriate Professional Indemnity Insurance including the level of cover and any
b) material changes to cover that occurred during the previous twelve months;
c) medical practitioner registration (as applicable);
d) continuous registration with the relevant specialist college or professional body; and
e) compliance with the annual mandatory continuing education requirements of their specialist college or professional body.

11.6. Continuous disclosure

Each Accredited Practitioner must keep the CEO continuously informed of matters which have a material bearing upon their Credentials and Scope of Clinical Practice, including;

a) ability to deliver health care services to patients safely and in accordance with their authorised Scope of Clinical Practice;
b) any adverse outcomes, complications or complaints in relation to the Accredited
c) Practitioner's patient or patients (current or former) of the Facility;
d) Professional Indemnity Insurance status;
e) registration with the relevant professional registration board, including any Conditions or limitations placed on such registration; and compliance with all relevant laws and any codes, policies, methods of best practice, directions or notices made or issued by a Regulatory Authority.

11.7. Advice of material issues

Without limiting By-Law 11.6, Accredited Practitioners must advise the CEO in writing as soon as possible but at least within two (2) days if any of the following matters occur and come to the attention of the Accredited Practitioner:

a) an adverse finding (formal or informal, current or former) made against him or her by any registration, disciplinary, investigative or professional body;
b) their professional registration being revoked, suspended or amended (including the imposition of any Conditions);
c) the initiation of any process, inquiry or investigation by the relevant board or coroner or tribunal (or equivalent body in any other jurisdiction, as applicable) or a health care complaints body (howsoever described) involving the Accredited Practitioner or the initiation of a legal process relevant to the medical practice which impacts or arises from their practice of medicine or provision of health care services;
d) any change in their Professional Indemnity Insurance, including but not limited to the

attaching of Conditions, non-renewal or cancellation;

e) their Appointment to Accreditation or Scope of Clinical Practice at any other facility, hospital or day procedure Centre is altered in any way other than at the request of the Accredited Practitioner;
f) they incur an illness or disability which may adversely affect their Current Fitness;
g) any claim, or any circumstance which may give rise to a claim, in respect of the management of a patient of that Accredited Practitioner at CH Hospitals (including all relevant details); or
h) they being charged with, or convicted of, any indictable offence or under any laws that regulate the provision of health care services or health insurance.

11.8. Medical records

Accredited Practitioners must:

a) maintain full, accurate, legible and contemporaneous medical records for each patient under their care or ensure that such adequate clinical records are maintained in the patient's Facility medical record:
b) in compliance with the Act and any applicable codes or guidelines published by AHPRA;
c) such that, in an emergency, another suitably qualified Accredited Practitioner can expeditiously take over the care of the patient;
d) in a way which enables the Hospital to collect revenue in a timely manner and any other data reasonably required in respect of a Hospital, including as a minimum:

    i. full and informed written patient consent;
    ii. particulars of all procedures, including pathology and radiology reports;
    iii. observations of the patient's progress;
    iv. notes of any special problems or complications;
    v. discharge notes, completed discharge summary and documentation of requirements and arrangements for follow-up; and

b) complete an operation report that shall include a detailed account of the findings at surgery, the surgical technique undertaken, complications and post-operative orders, and the full name of any anaesthetist and other Medical Practitioner present;
c) operation reports shall be written or dictated as soon as is practicable and the report signed by the attending Accredited Practitioner and made part of the patient's medical record;
d) ensure the provision of CMBS Item Numbers and prompt notification to the Facility of any subsequent change or addition to the Item Numbers;
e) complying with all legal requirements and standards in relation to the prescription, administration, discard and safeguarding of medication, and properly documenting all drug orders correctly and legibly in the Hospital's medication chart of the patient's Hospital medical record (including any process required for the use of off-label medication);
f) ensure that the medical records maintained by that Accredited Practitioner are sufficient for the review of patient care;
g) acknowledge and agree that medical records of patients of the Hospital are owned by Centaurus Healthcare.

11.9. Continuing education

Accredited Practitioners must:

a) by involvement in continuing education, keep informed of current practices and trends in the Accredited Practitioner's area of practice, by regularly attending and participating in clinical meetings, seminars, lectures and other educational programs, to maintain and improve their knowledge and to maintain and increase their skills;
b) meet all reasonable requests to participate in the education and training of other clinical staff of the Facility, the effect of which is to raise the level of competence of staff in general and improving patient care and relations between Accredited Practitioners and other staff; and
c) co-operate and participate in appropriate quality improvement activities, including satisfying the mandatory attendance and participation requirements of By-Law 9.3(a).

From 1 January 2023, the Medical Board of Australia (MBA) introduced some major changes for all doctors practicing in Australia. The new requirements for CPD from 2023 are as follows:

Doctors are required to:

- choose an accredited 'CPD Home' by January 2024
- complete an annual Professional Development Plan
- accrue a minimum of 50 hours of annual CPD
- complete education in three (3) core categories of CPD (see below)
- Complete CPR every three years as deemed appropriate by APHRA and the AMA requirements in the case of all Centaurus Healthcare and direct Endoscopy VMO's who administer sedative or anaesthetic agents. This includes both GP and specialist anaesthetists.

CPD Homes

All registered medical practitioners are required to choose a CPD Home. The Australian Medical Council has accredited all Medical Colleges and the AMA as CPD homes. Once aligned with a home, doctors must meet the requirements of the CPD program of their chosen CPD home.

CPD Hours and Categories

CPD is now measured in hours and all doctors, regardless of whether they are full or part time, will need to complete 50 hours per year. CPD is divided into three categories:

<table>
<tr><td>Educational Activities
This category expands knowledge, skills and attitudes e.g. webinars, lectures.</td><td>Minimum of 12.5 hours per year</td><td></td><td rowspan="3">Additional 12.5 hours in any category = total of 50 hours per year</td></tr>
<tr><td>Reviewing Performance
This involves reflection on feedback about a GP's work e.g. interactive activities, peer feedback, self-reflection on cases.</td><td>Minimum of 5 hours per year</td><td rowspan="2">25 hours minimum combined
= + 15 hours of either Reviewing Performance or Measuring Outcomes (or combination of the 2)</td></tr>
<tr><td>Measuring Outcomes
This involves ensuring quality</td><td>Minimum of 5 hours per</td></tr>
</table>

by using a GP's work data e.g. audits and research.	year		

11.10. Clinical activity

Accredited Practitioners must maintain a sufficient level of clinical activity in the Facility to enable the CEO, acting reasonably, to be satisfied that:

a) the Accredited Practitioner's knowledge and skills are current;
b) the Accredited Practitioner is familiar with the operational policy, procedures and practices of the Facility; and
c) the Accredited Practitioner is able to contribute actively and meaningfully to the division or department relevant to their Scope of Clinical Practice and to the Committee

11.11. Participation in Committees

a) Accredited Practitioners must participate in the Departmental meetings however named, in accordance with By-Law 9.3(a)
b) in addition to the requirement under By-Law 11.11(a), Accredited Practitioners must meet all reasonable requests to participate in, and contribute actively to, Committees established to co-ordinate and direct the various functions of the Facility.
c) Without limiting By-Law 11.11(a), the CEO may require any Accredited Practitioner to nominate him or herself to act as a member of a Committee. Before doing so, the CEO must have regard to:
    i. the Accredited Practitioner's current, or recent historical contribution to Committee or Committees at CH (absolutely and relative to the Accredited Practitioner's peers);
    ii. the Accredited Practitioner's clinical activity in the Facility (absolutely and relative to the Accredited Practitioner's peers); and
    iii. any extenuating circumstances which the CEO considers may reasonably preclude the Accredited Practitioner from acting as a member of a particular Committee (for example, extraordinary responsibilities as a carer or extraordinary voluntary commitments to the medical or general communities).

11.12. Emergency/disaster planning

Accredited Practitioners must:

a) be aware of their role in relation to emergency and disaster planning;
b) be familiar with CH safety and security policies and procedures; and
c) participate in emergency drills and exercises which may be conducted at the Hospital.

11.13. Criminal record checks

a) The Appointment of Accredited Practitioners is conditional on the person satisfactorily completing any forms that CH may require for the purpose of fulfilling CH's Private Hospital's obligations under applicable criminal records check legislation.
b) The Accredited Practitioner must undertake to CH that they are not a and:
    i. has not retired or resigned from, or had any previous employment or engagement terminated on the grounds that the Accredited Practitioner engaged in Reportable Conduct;

ii. has never been charged with or been the subject of an investigation as to whether they engaged in any Reportable Conduct; and
iii. will not engage in Reportable Conduct;

c) The Accredited Practitioner must inform CH immediately if they are unable to give the undertakings set out in By-Law 11.13(b).
d) Accredited Practitioners must provide authority to the Facility to conduct a criminal history check with the appropriate authorities in any jurisdiction at any time.

11.14. Notifiable Conduct and mandatory reporting

All Accredited Practitioners must comply with their obligations of mandatory reporting of Notifiable Conduct as prescribed in the Health Practitioner Regulation National Law Act 2009, as in force in each State and Territory.

a) CH recognises that national clinical guidelines and standards developed collaboratively by organisations such as:
   i. Australian Commission on Safety and Quality in Health Care;
   ii. National Health and Medical Research Organisation;
   iii. National Institute of Clinical Studies;
   iv. Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIPS);
   v. recognised authorities in evidence based medicine, such as the Cochrane Collaboration;
   vi. specialist training colleges and organisation accredited by the Australian Medical Council;
   vii. the clinical professional organisations and societies; and
   viii. various peak clinical non-government organisations) represent the current clinical 'best practice' for many areas of medicine, and should whenever possible and practicable, be consulted for guidance to support informed clinical decision-making and the development of pathways of care that yield optimal clinical outcomes. While all clinical decisions are, ultimately, the prerogative of the treating Accredited Practitioner, CH expects the use of evidence-based clinical guidelines and medicine unless the particular clinical circumstances of a patient requires otherwise and CH may initiate a review pursuant to By-Law 17 and take formal action with respect to Accreditation and Scope of Clinical Practice if the care provided to one or more patients, including post care follow-up, is below the expected standard of care.

11.15. Notice of leave

a) Where Accreditation has been granted in respect of the Facility, an Accredited Practitioner must use their best endeavours to notify the CEO in writing, at least four weeks in advance of planned leave and make appropriate arrangements for another Accredited Practitioner to take over the care and treatment of his/her patients during the Accredited Practitioner's absence.

12. Term of Appointment

a) All Appointments made pursuant to this By-Law 12 will be made for periods determined by the CEO, must not exceed three (3) years from the date of approval or one (1) year in respect of Accredited Practitioners age being 80 years or above.

13. Reaccreditation and practitioner requests to amend scope of practice

13.1. Notice to Accredited Practitioner

Not less than three months before the date fixed for expiry of the Accreditation of an Accredited Practitioner, the CEO must notify the Accredited Practitioner of the pending expiry of their Accreditation and the processes for applying for Re- accreditation and review of their Scope of Clinical Practice.

13.2. Apply for Re-accreditation

An Accredited Practitioner must apply for Re-accreditation before the expiration of the term of Accreditation in order to maintain Accreditation with CH.

13.3. Amendments

An Accredited Practitioner may make an application to the CEO for amendment of their Scope of Clinical Practice:

a) at the same time as making an application for Re-accreditation; or
b) at any other time.

13.4. Process

a) The CEO will forward applications for Re-accreditation and/or amendments to Scope of Clinical Practice, together with all other relevant information, to the Accreditation and Credentialing Committee for review and consideration.
b) Subject to CH policy, the processes for Reaccreditation and/or amending the Scope of Clinical Practice of Accredited Practitioners under this By-Law 13 will:
    i. include an assessment and review of the Accredited Practitioner's performance, Current Fitness, Credentials, character and ability to cooperate with management and staff at CH; and
    ii. be otherwise the same as for an initial Accreditation, save that By-Law 19.1 will not apply to Re-accreditation or amendments to Scope of Clinical Practice.

13.5. Review

All Accredited Practitioners will be subject to the processes of Re-accreditation and review of their Scope of Clinical Practice in accordance with the appointments cycle.

14. Investigations of Concerns, Allegations or Complaints

14.1. Chief Executive Officer may make investigations

The CEO may make inquiries regarding a concern raised, allegation or complaint against an Accredited Practitioner if the CEO considers that it warrants making such an inquiry, including in circumstances where the concern raised, or allegation or complaint made has or may result in:

a) patient health or safety could be compromised;
b) the efficient operation of the Hospital being threatened or interrupted;
c) the reputation of CH could be threatened;
d) the potential loss of the Hospital's accreditation or license;
e) the imposition of any conditions on the Hospital's license;

f) the interests of a patient or someone engaged in or at the Hospital could be affected adversely;
g) a law has been, or may be, contravened;
h) a breach of the Hospital's values and/or code of conduct; or
i) staff welfare or safety could be compromised.

14.2. Notice to Accredited Practitioners and procedural matters

a) The CEO will advise the Accredited Practitioner in respect of whom the concern, allegation or complaint has been made and the substance of the concern, allegation or complaint and provide the Accredited Practitioner with an opportunity to respond.
b) The CEO will decide on all procedural matters relevant to advising the Accredited Practitioner under By-Law 14.2(a), which may include a determination on:
    i. how the concern or issue in respect of the Accredited Practitioner will be dealt with under these By-Laws;
    ii. a requirement for a witness to be present at the time the Accredited Practitioner is advised and the designation of that witness. For example, a senior manager at the Hospital or the chairperson of a Committee where a Committee has been involved in the concern or issue to be raised with the Accredited Practitioner;
    iii. the extent and nature of any relevant records or documents to be provided or produced in connection with the concern or issue; and
    iv. any appropriate time frames and format of response by the Accredited Practitioner.
c) The Accredited Practitioner will be afforded the opportunity to be accompanied by a support person in the handling of any procedural matters pursuant to this By-Law 14. The support person is not to participate in the process. Should the support person be a lawyer, that same person must not act as a legal representative for the Accredited Practitioner.

14.3. Review by Facility Chief Executive Officer

If, having considered the Accredited Practitioner's response (if any), then:

a) the CEO may decide to take no further action;
b) if in the opinion of the CEO the matter can be dealt with appropriately by reviewing the Accredited Practitioner's Scope of Clinical Practice, the CEO must request a review of the Accredited Practitioner's Scope of Clinical Practice in accordance with By-Law 15;
c) if in the opinion of the CEO the matter cannot be dealt with appropriately by a review of the Accredited Practitioner's Scope of Clinical Practice, the CEO in consultation with the chairperson of the MAC may establish a Committee to consider the matter further; and the CEO may impose an interim suspension or conditions on the Accreditation of the Accredited Practitioner until such time as the CEO is satisfied that the concern, allegation or complaint has been resolved or until the outcome of a review in accordance with By-Law 15 or a decision with respect to appropriate action arising from consultation in accordance with By-Law 14.3(c).
d) There will be no right of appeal with respect to the imposition of an interim suspension or conditions.
e) The terms of reference, process, and reviewers will be determined by the CEO.

14.4. Committee to assess issue of concern

A Committee (either the MAC or sub-committee thereof) to assist the CEO established under By-Law 14.3(c):

a) must ensure the Accredited Practitioner has been advised in writing of the particulars of the allegation and invite the Accredited Practitioner to respond;
b) may invite the Accredited Practitioner to meet with the relevant Committee in person; and must provide the CEO with its written conclusions and/or opinions within 14 days and supported by reasons.

14.5. Notifiable Conduct and mandatory reporting in relation to any investigation

a) The CEO must comply with their obligations of mandatory reporting of Notifiable Conduct as prescribed in the Health Practitioner Regulation National Law Act 2009, as in force in each State and Territory.
b) The CEO must advise the Board Chair of any mandatory reporting made under By-Law 14.5(a).
c) The Accredited Practitioner must notify other facilities where they hold accreditation of the notification.

15. Review of scope of clinical practice in light of investigations of concerns, allegations or complaints

15.1. Surveillance of AHPRA registration database

The CEO will conduct periodic and active surveillance of the AHPRA registration database to ensure currency of registration and accuracy of any Conditions imposed.

15.2. Chief Executive Officer initiated internal review

The CEO may, at any time, direct the MAC Chairperson or other appropriate individuals as determined by the CEO to conduct an internal review of the Accreditation previously granted to an Accredited Practitioner including an assessment if necessary of Current Fitness and Credentials of the Accredited Practitioner and following such review, the MAC will make a recommendation to the CEO, through the MAC concerning the continuation, amendment, suspension or revocation of Accreditation. The CEO will make a final determination in relation to the matter, subject to the provisions of By-Law 20.2.

15.3. Chief Executive Officer initiated external review

The CEO may, at any time, consult with the Chair of the Medical advisory Committee in relation to an independent review of the Accreditation previously granted to an Accredited Practitioner including an assessment if necessary of Current Fitness and Credentials of the Accredited Practitioner and following such review, a recommendation to the MAC must be made concerning the continuation, amendment, suspension or revocation of Accreditation. Such a review process will result in a recommendation to the CEO who will make a final determination in relation to the matter, subject to the provisions of By-Law 20.2.

15.4. Notice to Accredited Practitioners

a) The CEO will advise the Accredited Practitioner in respect of whom a review is being conducted under either By-Law 15.2 or 15.3 of the commencement and substance of the review and the extent to which the Accredited Practitioner may participate in the review and that the Accredited Practitioner will be provided with an opportunity to respond during the review.
b) The CEO will decide on all procedural matters relevant to advising the Accredited Practitioner under By-Law 15.4(a) which may include a determination on:
    i. how the review in respect of the Accredited Practitioners will be dealt with under these By-Laws;
    ii. a requirement for a witness to be present at the time the Accredited Practitioner is advised and the designation of that witness;
    iii. the extent and nature of any relevant records or documents to be provided or produced in connection with the review; and
    iv. any appropriate timeframes and format of response by the Accredited Practitioner.
c) The Accredited Practitioner will be afforded the opportunity to be accompanied by a support person in the handling of any procedural matters pursuant to this By-Law 15. The support person is not to participate in the process. Should the support person be a lawyer that same person must not act as a legal representative for the Accredited Practitioner.
d) The CEO must advise the Board Chair that the review is being undertaken under either By-Law 15.2 or 15.3.

15.5. Action the Facility Chief Executive Officer may take following review

Following a review under By-Law 15.2 or 15.3 the CEO may direct that the Accredited Practitioner:

a) cease performing surgical, anaesthetic, or perform only defined procedures;
b) perform surgical, anaesthetic, only when assisted by another Accredited Practitioner qualified in the same field of practice;
c) practice in a restricted range, surgical, anaesthetic.

15.6. Notice of outcome of the review

a) The CEO must give written notice to the Accredited Practitioner where the CEO wishes to exercise their rights under this By-Law 15.
b) The CEO must notify the Board Chair of the outcome of any review undertaken under By-Law 15.

15.7. Notifiable Conduct and mandatory reporting in relation to review of scope of clinical practice

a) The CEO must comply with their obligations of mandatory reporting of Notifiable Conduct as prescribed in the Health Practitioner Regulation National Law Act 2009, (including in relation to any mandatory reporting obligations in relation to actions taken by the CEO following a review under By- law 15, as enforced in each State and Territory.
b) The CEO must advise the Board Chair of any mandatory reporting made under By-Law 15 (including in relation to any action taken in relation to the Accreditation of an Accredited Practitioner under By-law 15.5).

15.8. Not Contingent

The CEO's right to proceed with review(s) in accordance with this By-Law 15 is not contingent on the CEO having first carried out any review in accordance with By-Law 14.

16. Suspension

16.1. Suspension of Accredited Practitioners by Chief Executive Officer

The CEO may, and without having regard to By-Law 15, and where considered reasonable and appropriate in the circumstances following consultation with the MAC (and/or such other persons as the CEO considers appropriate) and the Board Chair, based on the information available to the CEO at that time:

a) suspend all or any portion of an Accredited Practitioner's Accreditation, including the privilege to use the operating theatre; or
b) impose Conditions on the Accreditation of an Accredited Practitioner, whenever the CEO considers:
    i. it is in the interests of patient care and safety in the Hospital;
    ii. it is in the interests of staff welfare or safety or workplace health and safety;
    iii. the behaviour or conduct of the Accredited Practitioner is such that it is unduly hindering the efficient operation of the Hospital at any time;
c) the Accredited Practitioner has breached any Conditions of Accreditation, including Conditions imposed by these By-Laws;
d) the behaviour or conduct of the Accredited Practitioner is bringing the Facility into disrepute or otherwise damaging the reputation of the Hospital;
e) the behaviour or conduct of the Accredited Practitioner is inconsistent with either the Code of Conduct or the Facility's mission or values statements;
f) the Accredited Practitioner has not provided satisfactory evidence on demand of their professional qualifications, current registration as a Medical Practitioner or Dental Practitioner or sufficient and current Professional Indemnity Insurance;
g) the practitioner has been found to have made a false declaration to the Hospital either through omission of important information or inclusion of false information; or
h) serious and unresolved allegations have been made in relation to the Accredited Practitioner (This may be related to a patient or patients of another facility not operated by the Hospital, including if these are the subject of review by an external agency including a registration board, disciplinary body, Coroner, complaints commission or another health service);
i) the Accredited Practitioner has failed to observe any of the terms and conditions of Accreditation;
j) the behaviour or conduct is inconsistent with a policy, procedure, direction or code of conduct in relation to the expected standard of behaviour or conduct at the Hospital;
k) the Accredited Practitioner fails to make the notifications required to be given pursuant to these By-laws or based upon the information contained in a notification suspension is considered appropriate;
l) the Accreditation, has been suspended, cancelled, restricted or made conditional by another health care organisation;
m) the Accredited Practitioner is the subject of a criminal investigation about a serious matter (for example a drug related matter, or an allegation of a crime against a person such as a sex or violence offence) which, if established, could affect their ability to exercise their Clinical Privileges safely and competently and with the confidence of the Hospital and the broader community;

n) the Accredited Practitioner has been convicted of a crime which could affect their ability to exercise their Clinical Privileges safely and competently and with the confidence of the Hospital and the broader community;

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

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

q) there are other unresolved issues or concerns in respect of the Accredited Practitioner that the CEO considers is a ground for suspension.

16.2. Notification of suspension decision and reasons

The CEO must:

a) notify the Accredited Practitioner of the decision to suspend and conditions and timeframes which will apply to reinstatement and must give reasons; and

b) invite a written response from the Accredited Practitioner within a timely manner of the CEO's notification.

c) The Accredited Practitioner will be afforded the opportunity to be accompanied by a support person in the handling of any procedural matters pursuant to this By-Law 16. The support person is not to participate in the process. Should the support person be a lawyer that same person must not act as a legal representative for the Accredited Practitioner.

16.3. Suspension effective immediately and right to claim

Suspension will become effective immediately upon notification to the Accredited Practitioner and it is a condition of Accreditation that the Accredited Practitioner acknowledges and agrees that suspension of his/her Accreditation shall not, in any circumstances, give rise to any right on behalf of the Accredited Practitioner to claim compensation from CH and the Accredited Practitioner further agrees that this By-Law may be used as an absolute bar to any proceedings in relation thereto.

16.4. Appeal rights

Unless otherwise provided in these By-Laws, the affected Accredited Practitioner will have the rights of appeal established by these By-Laws.

16.5. Notification to Board

The CEO will notify the Board Chair of any suspension of Accreditation of an Accredited Practitioner.

16.6. Notifiable Conduct and Mandatory Reporting

a) The CEO must comply with their obligations of mandatory reporting of Notifiable Conduct as prescribed in the Health Practitioner Regulation National Law Act 2009, (including in relation to any suspension of Accreditation of an Accredited Practitioner under By-law 16), as enforced in each State and Territory.

b) The CEO must advise the Board Chair of any mandatory reporting made under By-Law 16.7(a).

16.7. Alternative to Suspension

As an alternative to an immediate suspension, the CEO may elect to deliver a show cause notice to the Accredited Practitioner advising of:

a) the facts and circumstances forming the basis for possible suspension;

b) the grounds under the By-laws upon which suspension may occur;

c) invite a written response from the Accredited Practitioner, including a response why the Accredited Practitioner may consider suspension is not appropriate;

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

e) a timeframe in which a response is required from the Accredited Practitioner to the show cause notice:

f) Following receipt of the response the CEO will determine whether the Accreditation will be suspended. If suspension is to occur notification will be sent in accordance with the notification requirements of this By-law. Otherwise, the Accredited Practitioner will be advised that suspension will not occur at this stage; however, this will not prevent the CEO from taking other action at this time, including imposition of conditions, and will not prevent the CEO from relying upon these matters as a ground for suspension or cancellation in the future.

17. Cancellation of Accreditation

17.1. Immediate cancellation

Accreditation of Accredited Practitioners will be cancelled immediately by the CEO and, where considered reasonable and appropriate in the circumstances, in consultation with the MAC Chair, if, based on the information available to the CEO at that time:

a) the Accredited Practitioner is found guilty of Professional Misconduct by any inquiry, investigation or hearing by any disciplinary body or professional standards organisation;
b) the Accredited Practitioner ceases to be registered in the relevant profession, specialty and jurisdiction for which Accreditation has been issued;
c) the Accredited Practitioner is convicted of an offence involving sex or violence or any offence in relation to the Accredited Practitioner's practice;
d) the Accredited Practitioner fails, refuses or is unable to comply with the requirements and undertakings set out in By-Law 11.13, or is dishonest in respect of the undertakings given in By-Law 11.13(b);
e) any relevant screening authority in the Accredited Practitioner's jurisdiction determines that the Accredited Practitioner poses an unacceptable level of risk to children; or
f) the Accredited Practitioner's Professional Indemnity Insurance is cancelled, lapses or no longer covers the Accredited Practitioner's Scope of Clinical Practice to the reasonable satisfaction of the CEO (unless the situation is rectified by the Accredited Practitioner within 24 hours from when they become aware that their Professional Indemnity Insurance has been cancelled, lapsed or does not cover their Scope of Clinical Practice).

17.2. Unprofessional Conduct

Accreditation of Accredited Practitioners may be cancelled immediately if the Accredited Practitioner is found guilty of Unprofessional Conduct by any inquiry, investigation or hearing by any disciplinary body or professional standards organisation.

17.3. Cancellation on incapacity

An Accredited Practitioner's Appointment may be cancelled if, in the reasonable opinion of the CEO (having first obtained independent advice), an Accredited Practitioner becomes incapable of performing their duties for a continuous period of six months or for a cumulative period of six months in any 12 month period.

17.4. Cancellation when not immediate (this should be discussed)

Accreditation of an Accredited Practitioner may be cancelled by the CEO having, where considered reasonable and appropriate in the circumstances consulted with the Board Chair, by giving the Accredited Practitioner 1 month written notice if:

a) the Accredited Practitioner fails to observe the terms and Conditions of their Accreditation or fails to abide by these By-Laws or the Facility's policies and procedures and fails to rectify the breach;

b) the Accredited Practitioner, after due hearing, is considered by the CEO to have engaged in Professional Misconduct and/or Unprofessional Conduct;

c) the Accredited Practitioner is not considered by the CEO as having Current Fitness;

d) to do so would be in the interests of patient care or safety or in the interests of staff welfare or safety;

e) the Accredited Practitioner's registration is subject to conditions which are inconsistent with their continuing to be appointed as an Accredited Practitioner;

f) the Accreditation is no longer supported by the Organisational Need or Organisational Capabilities of the Hospital;

g) the Hospital ceases to provide support services required within the Scope of Clinical Practice of the Accredited Practitioner;

h) the conduct or continuing Accreditation of the Accredited Practitioner compromises the efficient operation or the interests of the Hospital;

i) the Accredited Practitioner's agreement with a contracted services provider for whom the Accredited Practitioner provides services terminates, or if the Accredited Practitioner's employment engagement with the contracted service provider terminates (excluding Consulting);

j) the Accredited Practitioner does not, without prior approved leave, provide services at the Hospital for a period of twelve months;

k) the Accredited Practitioner ceases to hold, in the CEO's opinion, current and adequate Professional Indemnity Insurance;

l) the Accredited Practitioner has applied for a review of the suspension of their Accreditation under By-Law 16.5 and on review the decision to suspend is upheld; or

m) there are grounds for suspension pursuant to By-Law 16.1 but in the circumstances, it is considered that suspension is an insufficient response.

17.5. Notification to Board

The CEO will notify the Board Chair of any termination of Accreditation of an Accredited Practitioner.

17.6. No appeal rights where immediate cancellation

No right of appeal will exist in respect of immediate cancellation pursuant to By-Law 17.

17.7. Immediate Cancellation at each Facility and no right to claim

a) The immediate cancellation of Accreditation of an Accredited Practitioner pursuant to By-Law 17.1 at CH will cause the automatic cancellation of Accreditation at any other subsidiaries operated or conducted by CH Private Hospitals and it is a condition of Accreditation that the Accredited Practitioner acknowledges and agrees that cancellation of his/her Accreditation shall not, in any circumstances, give rise to any right on behalf of the Accredited Practitioner to claim compensation from the Hospital or any subsidiaries and the Accredited Practitioner further agrees that this By-Law may be used as an absolute bar to any proceedings in relation thereto.

17.8. Notifiable Conduct and Mandatory Reporting

a) The CEO must comply with their obligations of mandatory reporting of notifiable conduct as prescribed in the Health Practitioner Regulation National Law Act 2009, as in force in each State and Territory.

b) The CEO must advise the Board Chair of any mandatory reporting made under By-Law 17.8(a) (including in relation to any termination of Accreditation of an Accredited Practitioner under By-law 17).

17.9. Alternative to Cancellation

As an alternative to an immediate termination, the CEO may elect to deliver a show cause notice to the Accredited Practitioner advising of:

a) the facts and circumstances forming the basis for possible cancellation;
b) the grounds under the By-laws upon which cancellation may occur;
c) invite a written response from the Accredited Practitioner, including a response why the Accredited Practitioner may consider cancellation is not appropriate;
d) if applicable and appropriate in the circumstances, any actions that must be performed for the cancellation not to occur and the period within which these actions must be completed; and a timeframe in which a response is required from the Accredited Practitioner to the show cause notice
e) Following receipt of the response the CEO will determine whether the Accreditation will be cancelled. If cancellation is to occur notification will be sent in accordance with the notification requirements of this By-law. Otherwise, the Accredited Practitioner will be advised that cancellation will not occur at this stage; however, this will not prevent the CEO from taking other action at this time, including imposition of conditions, and will not prevent the CEO from relying upon these matters as a ground for suspension or cancellation in the future.

18. Imposition of Conditions

18.1. Imposing Conditions in lieu of suspension or cancellation

a) In lieu of the suspension of the Scope of Clinical Practice or cancellation of Accreditation of an Accredited Practitioner, the CEO may elect to impose Conditions on the Accreditation or Scope of Clinical Practice of an Accredited Practitioner.
b) The imposition of Conditions may be recommended by the appointments Committee or scope of clinical practice Committee, but is at the ultimate discretion of the CEO.
c) The CEO must notify the Accredited Practitioner in writing of the imposition of Conditions, the reasons for it, the consequences if the Conditions are breached, invite a written response and advise of the right of appeal, the appeal process and the timeframe for an appeal.
d) If the Conditions are breached, then suspension of Scope of Clinical Practice or cancellation of Accreditation of an Accredited Practitioner may occur.
e) If there is held, in good faith, a belief that the competence and/or Current Fitness to practice of the Accredited Practitioner is such that continuation of the unconditional right to practise in any other Facility would raise a significant concern about the safety and quality of health care, the CEO will ensure that the imposition of Conditions is notified to the relevant professional registration board and relevant State or Commonwealth bodies.
f) The appeal procedure contained in these By-Laws will apply to an imposition of conditions under By-law 18.

18.2. Notification to Board

The CEO will notify the Board Chair of any imposition of Conditions on the Accreditation of an Accredited Practitioner.

18.3. Notifiable Conduct and Mandatory Reporting

a) The CEO must comply with their obligations of mandatory reporting of notifiable conduct as prescribed in the Health Practitioner Regulation National Law Act 2009, as in force in each State and Territory (including in relation to the imposition of Conditions on the Accreditation or Scope of Clinical Practice of an Accredited Practitioner) under By-law 20.1
b) The CEO must advise the Board Chair of any mandatory reporting made under By-Law Appeal Rights

18.4. No appeal rights against refusal of initial Accreditation

a) There shall be no right of appeal by an applicant against a decision not to grant an initial Accreditation as an Accredited Practitioner to the Facility or from any terms or conditions that may be attached to an approval of an initial Accreditation as an Accredited Practitioner at the Hospital.
b) There shall be no right of appeal if an approval of an initial Accreditation as an Accredited Practitioner at the Facility included an initial probationary period (as determined appropriate by the CEO) and at the conclusion of the probationary period the CEO determined that Accreditation would not be granted following conclusion of the probationary period. In such circumstances the Accredited Practitioner will be required, if they seek Accreditation at the Hospital, to make a further application for Accreditation that will be regarded as an application for an initial Accreditation as an Accredited Practitioner at the Hospital.

c) There shall be no right of appeal against a decision not to grant a temporary or emergency Urgent Accreditation
d) There shall be no right of appeal against a decision not to introduce a new or amended use of technology or procedure.
e) Should an applicant holding a current Accreditation as an Accredited Practitioner have that Accreditation rejected, either in whole or in part or varied by the CEO, the applicant shall have the rights of appeal set out within these By-Laws.

18.5. Appeal rights generally

Except where these By-Laws state otherwise (see By-Laws 10.4(g), 17.6, 19.1) an Accredited Practitioner who has Accreditation in respect of the Facility and whose Accreditation is amended, made conditional, suspended, cancelled, not renewed or conditionally renewed by the Facility, will have the rights of appeal set out in By-Law 20.

18.6. Concurrent appeal rights

Despite any other provision of these By-Laws, where an Accredited Practitioner has appeal rights under these By-Laws concurrently with appeal rights under any legislation or mandatory directive and/or policy in respect of the same circumstances, the appeal rights under these By-Laws will cease to be available to the Accredited Practitioner. For the avoidance of doubt, if this By-Law 19.3 applies, the Accredited Practitioner will not have appeal rights under these By-Laws but will continue to have the appeal rights available under any legislation or mandatory directive or policy.

19. Appeal Procedure

19.1. Appeal must be lodged in fourteen days

An Accredited Practitioner will have 14 days from the date of notification of a decision to amend, make conditional, suspend, cancel, not renew or conditionally renew their Accreditation to lodge an appeal against the decision. Such an appeal must be in writing and be lodged with the CEO.

19.2. Relevant Committee established to hear appeal

The CEO will establish an appeals Committee to hear the appeal. The appeals Committee must

as a minimum include:

a) the MAC Chair (or delegate);
b) the Executive Director of Nursing (Director of Nursing) (or delegate); and
c) a nominee of the appropriate professional college of the appellant.

19.3. Chief Executive Officer

If the decision being appealed and reviewed by the appeals Committee was made:

a) by the CEO personally or relates to a Facility at which the appellant was previously Accredited, then the CEO must not be a member of the appeals Committee hearing the relevant appeal; or
b) by a Delegated Authority, then that Delegated Authority must not be a member of the appeals Committee hearing the relevant appeal.

19.4. Chairperson

a) The chairperson of the appeals Committee will be the Board Chair.

19.5. One vote per member

a) Each member of the Appeals Committee will have one vote; and
b) if there is an equality of votes the chairperson shall have a casting vote in addition to a deliberative vote.

19.6. Notice

The appellant will be provided with appropriate notice by the appeals Committee and will have the opportunity to make a submission to the appeals Committee.

19.7. Submissions

The appeals Committee will determine whether the submission of the appellant will be in writing or in person, or both. The appellant must provide written submissions for the appeals Committee within the timeframe reasonably required by the appeals Committee.

19.8. No legal representation

Neither the appellant nor any party will have any legal representation at any meeting of the appeals Committee. The appellant is entitled to be accompanied by a support person, who may be a lawyer, but that support person is not entitled to address the appeals Committee.

19.9. Chairperson determines procedure of the appeals Committee

The chairperson of the appeals Committee will determine any question of procedure for the appeals Committee provided that it complies with the conventions of natural justice.

19.10. Final determination of the Appeals process

The appeals Committee will make a written recommendation to the CEO and the Board, which will consider the recommendation and the processes leading to the appeals Committee's recommendation. The Board will then make a determination regarding the appeal. The determination of CH Board will be final and binding.

19.11. No Stay

If an Accredited Practitioner appeals a decision to amend, make conditional, suspend, cancel, not renew or conditionally renew their Accreditation, the appeal will not stay the decision under appeal.

19.12. New Clinical Services, Procedures or Other Interventions

a) An Accredited Practitioner who proposes to perform a New Clinical Service, Procedure or Other Intervention at the Facility must apply in writing to the CEO for approval.
b) The CEO must refer the application to the relevant Committee which will advise on the safety, efficacy and role of the New Clinical Service, Procedure or Other Intervention in the context of the Facility's organisational Need and organisational Capabilities. This information is to also be shared with the Board

c) The relevant Committee will advise the Board and CEO:
    i. whether, and under what conditions, the New Clinical Service, Procedure or Other Intervention could be introduced safely to the Hospital; and
    ii. whether the New Clinical Service, Procedure or Other Intervention or equipment is consistent with the Accredited Practitioner's Scope of Clinical Practice.
d) The Board and CEO may seek additional advice about the financial, operational or clinical implications of the introduction of the New Clinical Service, Procedure or Other Intervention.
e) The Board and CEO may refuse permission for 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 and CEO must:
    i. be satisfied that the New Clinical Service, Procedure or Other Intervention is consistent with the Organisational Need and Organisational Capabilities of the Facility;
    ii. be satisfied that the appropriate indemnity and/or insurance arrangements are in place; and
    iii. notify the relevant Committee.

20. Management of Emergencies

In cases of an emergency or in other circumstances deemed appropriate, the CEO may take such actions as they deem fit in the interests of a patient. This may include a request for attention by an available Accredited Practitioner (other than the admitting Accredited Practitioner).

In such cases, the following provisions will apply:

a) the available Accredited Practitioner may make appropriate arrangements for referrals for the purposes of urgent or necessary consultations or treatment and will inform the CEO of such arrangements;
b) the CEO will, as soon as possible, notify the Accredited Practitioner under whose care the patient was admitted of the circumstances, of the condition of the patient and of the actions taken;
c) the available Accredited Practitioner will advise the Accredited Practitioner under whose care the patient was admitted of the action taken; and
d) the patient's care will usually be returned, as soon as possible, to the Accredited Practitioner under whose care the patient was admitted, who will then resume the further management of the patient's condition.

21. Reputation of the Hospital

21.1. CEO may require cessation of certain types of procedures, advice or treatment

The CEO may, from time to time, on the basis of ethical or economic grounds, or upon the basis that certain types of medical practice may damage the reputation of the Hospital (or otherwise attract adverse publicity), require an Accredited Practitioner to immediately cease carrying out certain types of procedures, giving certain advice or recommending certain forms of treatment.

21.2. Accredited Practitioner to cease upon notice from the CEO

On being notified by the CEO of a requirement under By-Law 22.1, the Accredited Practitioner will immediately cease to carry out such procedures, give such advice, or recommend such treatment.

21.3. Scope of clinical practice Committee to make recommendation to the CEO

a) Following a decision of the CEO under By-Law 22.1, the CEO will refer the matter to the Medical Advisory Committee for consideration and discussion. The Committee may convey comments or make recommendations to the CEO in relation to the decision. The CEO may, in its absolute discretion, affirm or vary the decision of the Committee.
b) There is no right of appeal against a decision of the CEO under this By-Law 22.

22. Admission and removal or transfer of patients

22.1. All admissions subject to approval

a) The privilege of the Accredited Practitioner to admit a patient to the Hospital will, at all times, be subject to approval of such admission by the CEO. The CEO will be entitled to refuse permission for the admission of any patient without giving a reason.

23. Disputes

23.1. By-Laws

a) Any dispute or difference which may arise as to the meaning or interpretation of these By-Laws will be determined by the Board Chair in consultation with the CEO.

23.2. Committees

a) Any dispute or difference which may arise as to the meaning or interpretation of the powers of any Committee established under these By-Laws or the validity of proceedings of any meeting, excluding the Appeals Committee, will be determined by the CEO or the Board Chair.

24. Revision of By-Laws

a) The Board Chair may from time to time following approval and recommendation from the Board and Hospital Executive review these By-Laws and may make, amend, suspend or rescind any By-Law.
b) The Board must review these By-Laws not less than every three years.

25. Schedule 1 – General Practice Anaesthetics

This schedule applies to all Accredited Health Practitioners who are Medical Practitioners registered in general practice who provide anaesthesia to patients in the hospital.

25.1. General

An Accredited Health Practitioner who is a Medical Practitioner registered in general practice and accredited to perform anaesthesia at the hospital **(GP Anesthetist)** will practice with care and diligence within the Scope of Practice indicated in their Accreditation Notification consistent with their clinical competency and experience. Emergency life-saving procedures performed outside these bounds are an exception to this requirement.

The GP Anaesthetist must maintain his or her anaesthetic skills and knowledge with a caseload commitment to anaesthesia that must be no less than any annual minimum set by the CEO and participate in an ongoing professional development in the field of anaesthetics.

An Accredited Practitioner who is a Medical Practitioner registered in general practice who is seeking to practice anaesthesia at the hospital requires a certificate of competency from a supervising Anaesthetist who holds a Fellowship of the Australian and New Zealand College of Anaesthetics. If the Accredited Practitioner has been practicing anaesthetics without a supervising Anaesthetist then

a certificate of competency should be obtained from the Medical Superintendent or Chair of the MAC of the previous hospital at which the Accredited Practitioner worked.

25.2. Quality Assurance and Continuing Professional Development

Every GP Anaesthetist must participate in a triennial quality assurance and continuing professional development program in line with the Maintenance of Professional Standards (MOPS) program drawn up and agreed to by the Joint Consultative Committee on Anaesthesia (JCCA), a tripartite committee of the Australian and New Zealand College of Anaesthetists (ANZCA), the Australian College of Rural and Remote Medicine (ACRRM) and The Royal Australian College of General Practitioners (RACGP).

Every GP Anaesthetist must maintain a log book or similar record of their anaesthesia caseload and continuing professional development activities consistent with the requirements of the JCCA or other relevant body. At a minimum, log books should contain de-identified information on the age and gender of each patient, the date and anaesthesia performed, and the outcome and any complications. Special conditions may be imposed by the CEO having received the advice of the MAC on a GP Anaesthetist.

Every Gastroenterologist, practitioners conducting colonoscopies at the facility must:

- Hold current certification or recertification; or

Be in the process of obtaining certification, or recertification.

For Practitioners:

- You will need to have been certified or recertified within the past 3 years; or
- Be in the process of obtaining certification or recertification by GESA

Appendix 1 - Application for Accreditation of a VMO

DIRECT ENDOSCOPY

CENTAURUS HEALTHCARE

Medical Application for Credentialing & Scope of Practice

Please note: If you need to correct any error in your application, please initial the correction.

Please attach to this form:

- Current curriculum vitae including certified copies of all original qualifications
- Copy of current medical registration/s
- Copy of current medical indemnity insurance certificate
- Continuing professional development (CPD) statements for last 3 years
- Copy of 100-point ID check i.e driver's license and passport
- Copies of relevant Visa documents (if applicable)
- Current vaccination record
- National police history check
- International police check if applicant has lived overseas for 12 months or longer during the past 10 years

1. Applicant and contact details

Surname	
Given Name/s	
Previous name Please include your previous name appearing on certificates	
Date of Birth	
Place of Birth	
Residency status (Australian citizen/permanent/ temporary resident)	
Professional Address	Postcode
Phone (BH)	
Phone (AH)	
Mobile	
Email address	
Postal Address (if different to Professional Address)	

PRIMARY SPECIALTY	
Sub-specialty Or Area of special interest (If Applicable)	
Secondary Speciality (If Applicable)	

2. Application for scope of clinical practice*

I wish to apply to define my scope of clinical practice to undertake the following:

Position/Classification Sought
Scope of clinical practice sought (Please use additional pages if required)

**Please attach a copy of your full CV to this application*

3. Qualifications

(Must include; Primary Medical Degree, Specialist Qualifications, Procedural Qualifications – **must be certified copies**)

Qualification	University/organisation	Year obtained

Other training and clinical experience

With respect to your response in Question 2, please provide details of relevant clinical experience and post-qualification training.

Qualification	University/organisation	Year obtained

4. Clinical appointments

(a) Provide details on all current and previous clinical appointments (including names of organisations and dates of appointment) or other places of practice (for example, general practice).

Organisation	Term of appointment
Major appointment:	to
Other appointments:	to
	to
	to
	to

(b) Have you ever been denied a defined scope of clinical practice?	Yes ☐ No ☐
(c) Has your right to practice ever been withdrawn, suspended, terminated or reduced?	Yes ☐ No ☐

If you answered YES to either of the above questions, please provide full details.

5. Academic appointments/teaching experience

Provide details on current and previous teaching appointments (including names of organisations and dates of appointment).

Organisation	Status/level	Term of appointment
		to
		to
		to
		to
		to

6. Continuing medical education/continuing professional development

(a) Provide details of your involvement in current continuing medical education/continuing professional development. Include name of the college/organisation program in which you are enrolled and maintenance of activity log book.

(b) Have you satisfied the continuing medical education/continuing professional development requirements for your college membership/fellowship?	Yes ☐ No ☐

For anaesthetist only

Direct Endoscopy requires all anaesthetic VMOs to complete Advanced Life Support course each three years through a reputable provider.

Please provide details of Current Advanced Life Support including a copy of current certificate

For Gastroenterologists only

The Colonoscopy Clinical Care Standard requires Direct Endoscopy to ensure credentialed colonoscopists provide evidence of independent certification of performance indicators as documented in the standard.

Direct Endoscopy requires all gastroenterology VMOs to provide evidence of certification or current enrolment/participation in the GESA Colonoscopy Recertification Program or similar.

Please provide details of enrolment, participation or certification as described above.

7. Clinical review/peer review

Do you regularly participate in formal quality and peer review activities? Yes ☐ No ☐

Provide details of quality/peer review activities.

8. Health service engagement activities

Are you prepared to conduct/participate in educational, audit or research activities occasionally as requested? Yes ☐ No ☐

9. Have you any other information to support this application?

10. Regulatory and indemnity information

Medical Board of Victoria/Australia Registration Is this registration temporary? If yes, provide details. (Attach a copy of current registration certificate)	Yes ☐ No ☐
If you have registration pertaining to an area of need, please detail the type of assessment undertaken prior to registration	
Are you registered as a medical practitioner in any other state or territory of Australia, or in another country? If so, please specify.	Yes ☐ No ☐
If you have a specific registration and/or are required to undertake supervision please provide details including name and location of supervisor and frequency of supervision	
Do you have any conditions or restrictions placed on your registration (either in Victoria or elsewhere)? If so, please provide full details	Yes ☐ No ☐
In the past have you ever had any conditions or restrictions placed on your registration (either in Victoria or elsewhere)? If so, please provide full details	Yes ☐ No ☐

Current medical indemnity cover - attach a copy of current policy renewal certificate	
Is your proposed scope of clinical practice reflected in or covered by your current medical indemnity insurance?	Yes ☐ No ☐
Has there ever been or are there currently pending any claims, settlements or judgements against you?	Yes ☐ No ☐
Has your current or any previous medical defence organisation/insurer ever excluded or reduced any specific area of practice or terminated or denied coverage?	Yes ☐ No ☐
If the answer to any of the above is YES, please provide a detailed explanation (and specify the name of the relevant medical defence organisation/insurer).	
Do you have a Provider number? If YES, is it subject to any restrictions? If restrictions apply, please provide full details.	Yes ☐ No ☐ Yes ☐ No ☐
Are you a recognised specialist under the relevant jurisdiction for the purposes of the payment of Medicare benefits?	Yes ☐ No ☐

11. Health status

Do you have a disability/health issue that: • impact on your ability to perform any of the cognitive and physical functions which would fall within the scope of practice that you are seeking in this application? • require special equipment, facilities or work practices to enable you to perform any aspect of the scope of practice relating to this application? Or • might be relevant to determining your scope of practice? (In answering this question, please have regard to publications of the Medical Practitioner's Board of Victoria available at www.medicalboardvic.org.au; under 'doctors health', such as the *Blood borne infectious diseases policy,* which limits who may perform 'exposure prone procedures').	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
If YES, please provide details of the disability/health issue, its impact on your ability to carry out the scope of practice sought, and details of any special equipment facilities or work practices required.	

This information can be provided on this form or, if preferred, provide the information in a sealed envelope marked 'confidential attention of Medical Director' appended to this application. Indicate additional information is attached to the application. This information is sought to enable an assessment to be made as to whether you can safely perform the inherent/reasonable requirements of the work which you are seeking to perform at the hospital by submitting this application, or whether any reasonable adjustments might be required to ensure that you can work at the hospital in a way that ensures patient safety.

12. Disclosure about disciplinary actions/criminal activity

Have you ever been the subject of disciplinary action in the course of your work as a medical practitioner?	Yes ☐ No ☐
If YES, please describe.	
Have you ever been the subject of prior disciplinary action or professional sanctions imposed by any registration board (whether in Victoria or elsewhere)?	Yes ☐ No ☐
If YES, please describe.	
Have you ever been the subject of any investigation, inquiry or findings by any registration board (whether in Victoria or elsewhere) in relation to your ability to practise or have direct patient contact, or regarding your professional performance or your professional conduct?	Yes ☐ No ☐
Have you ever been convicted or found guilty of any criminal offence, including a drug or alcohol related offence? Are you the subject of pending criminal charges?	Yes ☐ No ☐ Yes ☐ No ☐
If YES to any of the above, please provide full details. Or if you prefer, provide the information in a sealed envelope marked 'confidential for medical director only' appended to this application, and indicate here that additional information is provided separately in this manner.	
Have you ever had any adverse findings made against you that may be relevant to your appointment (in addition to anything you may have noted above)?	Yes ☐ No ☐
If YES, please provide full details.	

If you require further space to answer any questions, please attach separate pages, identified with the relevant section number.

13. Referees

Please provide details of three independent professional referees, preferably at least two in your speciality, who have been in a position to judge your qualifications and experience during the past five years and who have no conflict of interest in providing a reference.

Referee 1	
Name	
Position held currently	
Professional address	Postcode:
Phone (BH)	
Phone (Mobile)	
Fax	
Email address	

Referee 2	
Name	
Position held currently	
Professional address	Postcode:
Phone (BH)	
Phone (Mobile)	
Fax	
Email address	

Referee 3	
Name	
Position held currently	
Professional address	Postcode:
Phone (BH)	
Phone (Mobile)	
Fax	
Email address	

14. Agreement/undertakings

I understand that in assessing my application for appointment as a visiting medical practitioner, the health service will make additional enquiries as to my suitability for the position.

I authorise the health service to conduct a criminal history check in relation to my history.	Yes ☐ No ☐
I authorise the health service to obtain information relevant to my application from the Medical Board Australia and any other board regulating health practitioners, whether in Victoria or elsewhere.	Yes ☐ No ☐
I authorise the health service to obtain information relevant to my application from my current and any previous medical indemnity organisation/insurer.	Yes ☐ No ☐
I authorise the health service to obtain information relevant to my supervision requirements (where applicable).	Yes ☐ No ☐
I authorise the health service to seek information as to my past experience, performance and current fitness from my referees and from other persons as the health service considers appropriate, including any relevant health service, college or other professional organisation.	Yes ☐ No ☐
I authorise access to the above information by representatives of the health service's credentialing committees.	Yes ☐ No ☐
If appointed, I agree to familiarise myself with relevant hospital by-laws, policies and procedures and to abide by them.	Yes ☐ No ☐
If appointed I agree to use the established communication systems to keep myself informed of changes at Direct Endoscopy	Yes ☐ No ☐
If appointed, I agree to abide by confidentiality and privacy obligations and understand that breaches my result in the cessation of my appointment.	Yes ☐ No ☐
I agree to notify the Medical Director of a situation which may impact on my ability to exercise my scope of clinical practice, whether due to medical registration or other matters.	Yes ☐ No ☐
If appointed, I agree to comply with relevant ongoing educational/certification programs of my college/association/joint consultative committee and to furnish details to the health service on an annual basis as requested by the Medical Director.	Yes ☐ No ☐
If appointed, I agree to participate in annual performance appraisal.	Yes ☐ No ☐
I agree to promptly notify the Medical Director of any adverse clinical incident I am involved in or become aware of and complete an incident report form	Yes ☐ No ☐
If appointed, I agree to work within my defined scope of clinical practice and to make a further application should I seek to extend the scope of clinical practice granted to me.	Yes ☐ No ☐
If appointed, should any question as to my credentialing or clinical practice arise, I agree that the health service may make such enquiries as it considers necessary to assess whether that credentialing or my scope of clinical is appropriate	Yes ☐ No ☐
I agree to provide a copy of my current registration, insurance and hand hygiene certificates, ensuring that I renew these documents annually. http://www.hha.org.au/LearningPackage/olp-home.aspx	Yes ☐ No ☐

I agree to complete the online education module on "Open Disclosure". http://vhimsedu.health.vic.gov.au/opendisclosure/topics/topic1/page1.php	Yes ☐ No ☐
I agree to provide photographic identification.	Yes ☐ No ☐

As recommended under the Standard for Credentialing and Defining the Scope of Clinical Practice of the Australian Commission for Safety and Quality in Health Care with respect to the information required for initial credentialing of a medical practitioner, the health service requires that the following declaration is completed by the applicant.

I hereby declare that I have not been subject to any prior change to the defined scope of clinical practice, or denial, suspension, termination or withdrawal of the right to practice (other than for organisational need and/or capability reasons) in any other organisations and that I have not been subject to any prior disciplinary action or professional sanctions imposed by any registration board.

I hereby declare that the information contained in this application is true and correct.

Signature of Applicant..... Date...../...../.....

Please note: If for any reason you are unable to sign the Declaration above, please explain the circumstances.

Applications for credentialing and scope of clinical practice are considered by Direct Endoscopy's Credentialing Committee.

Additional information regarding the declaration

DIRECT ENDOSCOPY

CENTAURUS HEALTHCARE

Health service use only

Applicant's name:	**Checked (✓)**
1. Contact details provided	☐
2. Qualifications	☐
3. 100 Point ID check	☐
4. Training and experience	☐
5. Clinical appointments	☐
6. Continuing medical education/continuing professional development (CPD, ALS, GESA)	☐
7. Medical registration and medical indemnity currency	☐
8. Provider number	☐
9. Specialist status	☐
10. Referees	☐
11. Existing contract/employment arrangements checked and relevant documentation available	☐
12. Signed VMO bylaw agreement	☐
13. Declaration signed	☐
14. Other comments	

Application details checked by: _____

Signature _____ Date / /

Decision of the DE Credentialing Committee:

Application Approved ☐ Declined ☐ (please state reason/s) Date / /

Detail reason/s for Declined application:

Letter to applicant advising outcome of application? Yes ☐ Copy Attached ☐

Approved Applicant:

Orientation provided: Date / /

☐ Tour, meet & greet ☐ Fire and safety ☐ Policy & Procedure manuals

☐ Documentation ☐ Facilities & equipment

Other: _____

Name and signature: _____

Reference:

Safer Care Victoria, 2020, Credentialing and scope of clinical practice for senior medical practitioners' policy

DIRECT ENDOSCOPY

CENTAURUS HEALTHCARE

Workforce Health Form

This form is to be completed by all staff on / before commencing employment and handed to the Director of Nursing

Name: _____ **Date of Birth:** _____

Date of Commencement: _____

Risk Category A ☐ B ☐ C ☐

Disease	Please attach a copy of the required evidence for each disease				
Diphtheria/Tetanus/Pertussis (Whooping cough) Booster	*Immunisation Record*	☐ Yes	*Date of last booster:* _____		
Hepatitis B	*Serology*	☐ Yes	**Result** ≥10 mIU/mL		☐ Yes
Measles-Mumps-Rubella (MMR)	*Immunisation Record -2 vaccinations*	☐ Yes	OR	*Serology*	☐ Yes
Varicella (Chickenpox)	*Immunisation Record -2 vaccinations*	☐ Yes	OR	*Serology*	☐ Yes
Hepatitis A	*Immunisation Record*	☐ Yes	*(If available)*		
COVID-19	*Immunisation Record*	☐ Yes	*(Number of doses as required by jurisdiction or local policy)*		
Influenza	*Immunisation Record*	☐ Yes	*(most recent date of vaccination)*		

Other screening questions

Do you have allergy or sensitivities to the following:

Latex	Hand Rubs	Surgical Scrub Solution	Liquid Hand Hygiene Solutions
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Do you have a health condition that places you at an increased risk of infection?

☐ **Yes it is:** _____ ☐ **No**

Tuberculosis [TB] Risk Screening Tool [Category A and B HCW to Complete]

Symptoms requiring investigation Do you have any of the following symptoms that are not related to an existing diagnosis or a condition being managed by a doctor? [Tick any that apply]:	☐ Cough for more than 2 weeks ☐ Coughing up blood in the past 4 weeks ☐ Unexplained fevers, chills of night sweats in the past 4 weeks ☐ Loss of >5% of your body weight in the past 3 months
Previous Treatment, Screening or Susceptibility Have you ever [Tick any that apply]:	☐ Been treated for active TB or Latent TB infection? If yes, then please state the year and the country where you were treated. Year:_____ Country:_____ ☐ Had a chest X-ray reported as abnormal? ☐ Been referred to or have been reviewed at a TB Service or Chest Clinic in Australia? **Have you had a Tuberculin Skin Test [TST] test or QuantiFERON Gold Test? If yes, please provide a copy of the test results**
TB Exposure Risk History	Is your country of birth listed as a high TB incidence country? [Evidence of testing required if tick yes) ☐ Yes ☐ No Have you spent a total of 3 months or more [cumulative] living in or visiting countries with a high TB incidence? [Evidence of testing required if tick yes) ☐ Yes ☐ No Have you had direct contact with a person with infectious pulmonary TB whilst not wearing a P2 / N95 mask? [Evidence of testing required if tick yes) ☐ Yes ☐ No

I am aware that immunity to vaccine preventable diseases according to the risk category of my role is a requirement for employment. I understand that in some jurisdictions it is mandatory to receive COVID-19 immunisation to work in a health facility unless I have a medical exemption or local policy does not require this in accordance with the applicable State or Territory law.

If I refuse to be tested and/or receive immunisation for vaccine preventable diseases I understand that this may result in withdrawal of an offer of employment, redeployment to a lower risk area or could result in termination of my employment.

If I am not able to provide evidence of immunity to a vaccine preventable disease, I understand that I will be asked to attend my GP and have blood taken and tested for the presence of antibodies to the listed disease and / or receive immunisation at my own expense. I understand that I will be asked to provide evidence of immunisation and/or test results to my employer.

I understand that there is no reliable test for immunity to Pertussis [Whooping Cough] and I am expected to provide evidence of immunisation against Pertussis within the past 10 years and obtain a booster every 10 years at my own expense. After receiving a booster, I will provide evidence of this to my employer for entry on the immunisation register.

I understand that some answers to the questions in the TB Risk Screening Tool may result in referral to a TB Clinic for follow up and /or I may be required to have a Tuberculin Skin Test [TST] or QuantiFERON Gold test at my own expense in order to exclude latent TB infection. I understand that if I was born or have lived in or visited for >3 months in a TB high incidence country I will be expected to provide evidence of TST or QuantiFERON Gold test results. I understand that if in future I spend >3 months in a TB high incidence country I will be expected to have a further TST or QuantiFERON Gold test upon my return and provide evidence of this to my employer.

In Victoria I understand healthcare workers in Category A & B and in NSW, Category A healthcare workers must have annual influenza vaccination by a certain date. If I am unable to be immunised for influenza, I understand that I must supply medical evidence of this. If I am unable to be immunised against influenza, I agree to wear a surgical mask during all patient contact from 1st June to 30th September each year.

Signature of staff member:_____ **Date:** _____

OFFICE USE ONLY:

Reviewed by Infection Prevention and Control Consultant:

Action Required: ☐ Yes ☐ No

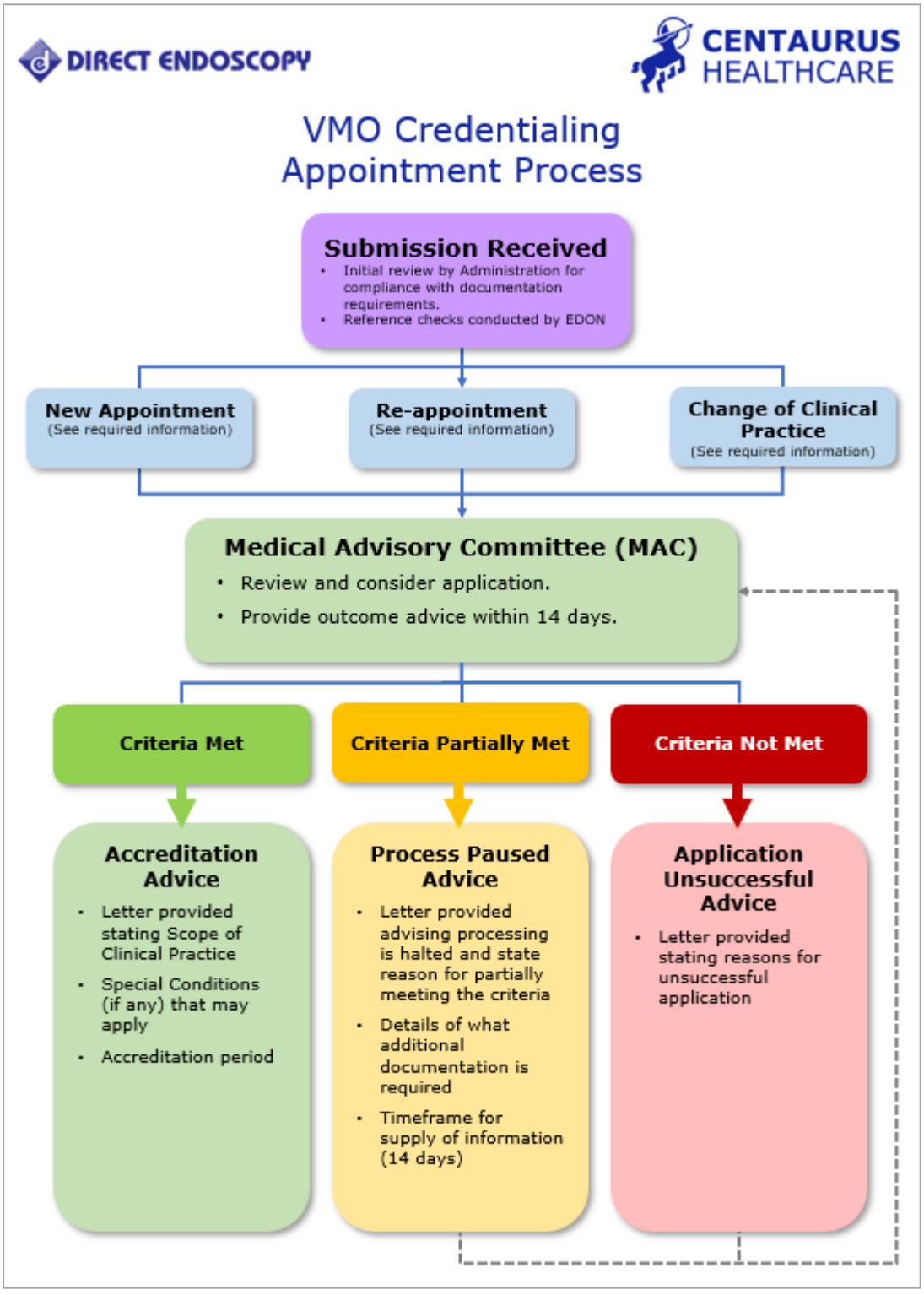
1. **Hep B non-responder – Hep B prophylaxis required within 72 hours of exposure. (Follow *Blood and Body Substance Exposure policy*)** ☐
2. **Please provide:**
   - Serology for Hep B ☐
   - Immunisation Record or Serology for: ☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella
   - Evidence of vaccination for: ☐ Annual Influenza (if relevant) ☐ COVID-19
   - Evidence of diphtheria/tetanus/pertussis booster in last 10 years ☐ Next booster due:
3. DON/CSM to complete NHHI Generic Skin Care Questionnaire and Assessment Form
   Monitor skin integrity and report and changes to DON/CSM ☐
4. Please see your GP immediately for referral to a TB Clinic ☐
5. Please see your GP immediately for QuantiFERON Gold test or Tuberculin Skin Testing ☐

Feedback provided to Staff member:

_____ _____

(Signature) *(Date)*

Appendix 2 – VMO Credentialing Process Flowchart



Appendix 3 – VMO Reference Check

DIRECT ENDOSCOPY

CENTAURUS HEALTHCARE

VMO Credentialing – Reference Check

Name of Applicant:

Referee's Name:

Referee's position:

Referee's contact number:

1. Relationship with the applicant

When and where have you worked/are working with the applicant?

What was/is the applicant's role?

What was/is the relationship between you and the applicant (supervisor/co-worker etc)?

2. Past performance

What were/are the applicant's major responsibilities in their most recent/current role?

How would you rate the applicant's quality of work?

Please circle:

Excellent Above average Average Below average Poor

Did you receive any complaints about the applicant from other staff or patients? Yes / No

Are you aware of any professional conduct that may be relevant for us to consider?

3. Ability to fulfil role being applied for:

How would you rate the applicant's skill and/or experience in relation to the following selection criteria?
(1-10; 1 being poor, 10 being excellent)

a) Clinical skills
b) Verbal communication skills
c) Organisation skills
d) Time management skills
e) Written communication skills

Is there any reason why we should not credential the applicant for the position applied for? Yes / No

Comments: _____

Interviewer: _____ **Date:** ____/____/____

Attach the completed reference check to the Application for Credentialing.