I. PREAMBLE TO BY-LAWS AND INTERPRETATION

The purpose of these By-Laws is to ensure that all patients admitted to the Hospitals receive the best possible care and treatment and to ensure a consistently high level of professional performance by all practitioners. The Hospital is subject to the provisions of the Health Services (Private Hospitals and Day Procedure Centre's) Regulations 2013 and its annexures, which amongst other things, outlines the obligatory requirements imposed on the hospital.

These By-Laws set out the conditions upon which visiting practitioners who act in accordance with the provisions of the Hospital's By-Laws and other applicable regulations. Compliance with these By-laws and regulations is determined by the Medical Director. Copies of the Hospital's By-Laws and any other relevant documents are available from the Medical Director.

The Annexure to these By-Laws form an integral part of the hospitals internal regulations and are intended to ensure consistent application of the processes for accreditation in concordance with ADSC recommendations.

In this document, unless context requires otherwise:

Accreditation: Means the credentialing of Visiting Medical Practitioners for the purpose of granting clinical privileges in accordance with: Safer Care Victoria's Victorian clinical governance framework and; the Credentialing and scope of clinical practice for senior medical practitioners' policy or, context demanding, the accreditation of the hospital by an external organization.

AHPRA: the Australian Health Professionals Regulation Authority, which manages the registration and renewal processes for health practitioners and students around Australia.

ANZCA: Australian and New Zealand College of Anaesthetists

The Endoscopy Centre: TEC Refers to the conglomeration of North West Day Hospital and Westpoint Endoscopy Day Hospital

Medical Director: Medical Director of North West Day Hospital & Westpoint Endoscopy Day Hospital

MAC: Medical Advisory Committee

Practitioner: Medical Practitioners as registered by APRHA in Australia

Recommendations: Non-binding advice provided by an external organization (some recommendations may be made binding by these laws)

Regulations: Mandatory directives to which the hospital and its employees are subject.

2. THE ENDOSCOPY CENTRE QUALITY POLICY

The Endoscopy Centre and its management have developed and approved the following quality policy:

To provide high quality, safe and caring service in a friendly and professional environment and in order to maintain certification to and the National Safety & Quality Health Standards Version 2 accreditation via the Australian Council on Healthcare Standards. The Endoscopy Centre will strive to continually improve the services it offers through the continual assessment of procedures, equipment and standards to provide state of the art service and patient care wherever possible.

Moreover, the hospital encourages continual improvement in the quality of care and services provided and believe this will be enhanced by:

- Accreditation or certification by the Australian Council on Healthcare Standards using the framework of the National Safety and Quality Health Service Standards Version 2 to protect the public and improve the quality of care and services the centres provide.
- The implementation of appropriate credentialing systems and processes, including delineation of clinical management systems, including clinical practices guidelines, protocols or pathways as appropriate.
- Emphasis on staff training and development in all aspects of quality improvement and the roles and responsibilities of all staff in the implementation of a quality- focused culture appropriate to the hospital
- A multi-disciplinary team approach to the provision of care and services that includes the patient, their families and carers and;
- Integrated quality and safety improvement systems and processes, which include but are not limited to, comprehensive clinical review encompassing clinical, patient and staff satisfaction, health and safety, functional improvement and financial outcomes focusing on organizational performance.

3. Credentialing of Visiting Practitioners

1. Categories of Visiting Practitioners

Each Person appointed as a Visiting Practitioner to TEC shall be appointed to one of the following categories:

a) Specialist Visiting Practitioner
b) Procedural General Practitioner

2. Term of appointment of visiting Practitioners

All appointments to a position of visiting practitioner shall, unless otherwise determined by the MAC, be for a period of three (3) years; ongoing appointment during this period is dependent on the furnishing to the hospital, of evidence of: Annual medical registration; medical indemnity insurance; Hand Hygiene competency; current Advanced Life Support/airway management competency (Anaesthetists only); statement of continuing education.

3. Process for the application for appointment/re-appointment

The Medical Director, or delegate such as the Director of Nursing shall provide each medical practitioner seeking appointment/re-appointment with an "application for appointment to visiting medical staff", which must be completed and submitted to the Medical Director or delegate along with any supporting documents. A copy of these By-Laws shall be made available to the applicant upon request.

4. Consideration of Application for Appointment

Upon receipt of a duly completed "application for Appointment" form:

a) The *MAC* and specialist nominated shall consider the application in the context of the hospital's business plan and objectives and determine whether, pursuant to section 4(b), the application is to be given further consideration.
b) The Medical Director, or delegate will contact the referees (initial appointment only) and will also verify the applicant's qualifications, credentials and insurance.
c) The Medical Director shall table the application, and any relevant findings resulting from inquiries referred to in section 4(b), before the Medical Advisory Committee for consideration of initial credentialing and subsequent recredentialing.
d) The Medical Director, as convening chairperson of the Medical Advisory Committee, shall make the final determination as to the application and shall have complete discretion to approve (or disapprove) each application.
e) In the event of an application for Credentialing being made shortly after a Medical Advisory Committee meeting the Medical Director may "Temporarily" approve a Visiting Practitioner to provide services to patients at TEC provided that the information required in section 4(b) has been obtained. This "Temporary" approval must then be placed on the agenda for the next scheduled MAC meeting for confirmation (or disapproval) as the case may be.
f) An urgent application for and approval of Credentialing may be made in the manner described in section 4(e) in the event that is it necessary to have a previously non TEC Credentialed Visiting Practitioner substitute for a TEC Credentialed VP in order to prevent the cancellation of a scheduled list.

4. Confidentiality and Notification of Decision

The proceedings involved in considering whether or not to grant accreditation and subsequently clinical privileges are to be held in the strictest confidence and are thus not to be discussed outside of the appropriate forum.
The Medical Director, or delegate, shall inform applicants of the outcome of their application.

5. Scope of Practice.

The request for any new procedures to be undertaken at The Endoscopy Centre will be presented to the Medical Director by the requesting VMO. Before any new services can be implemented at The Endoscopy Centre the service must be in line with the VMO's scope of practice. This will be verified against credentials to ensure the VMO has qualifications to support this specialty. It is the legal responsibility of The Endoscopy Centre to ensure adequate systems are in place for services to be provided by medical practitioners in accordance with identified community needs and within the capability of the facility.

6. Responsibilities of accredited VMO

A. Inability to Contact Responsible VMO

Where a situation arises where, in the opinion of the Registered Nurse who is in charge of the patient at the time, requires the attention of the VMO, every reasonable effort will be made to communicate with the VMO with regard to the situation and consult with him/her as to the care and treatment of the patient. However, if the VMO cannot be contacted, TEC has the right to take whatever action it considers necessary in the interest of the patient. This may include the calling of another VMO to care for the patient, or the transfer of the patient to hospital. In either case the VMO will be advised of the action as soon as possible.

B. Consent for Medical Treatment

TEC provides facilities and nursing care for the treatment and management of patients of VMO. It is the responsibility of the VMO to ensure that the consent of his/her patients to the nature and form of all treatment is obtained.

C. Medical Record Documentation

During the course of a patient's treatment at TEC, concise, pertinent and relevant information shall be documented in the patient's medical record.
All orders for treatment of the patients shall be clearly conveyed to the nursing staff by the VMO directing such treatment.
On conclusion of treatment a procedure report shall be written by the VMO containing a description of the procedure performed and all relevant findings.
The nursing staff must be provided with clear instructions regarding discharge of patients and the arrangements for follow-up.

D. Disclosure of Patient Information

TEC is committed to the protection of personal privacy of our patients, staff and other clients. Our policy is based on the Health Privacy Principles and the National Privacy Principles. The policy deals with the collection, use and disclosure of personal health information as well as access and correction, data security and data retention.

E. Open Disclosure of Adverse Patient Events

TEC has a policy of open disclosure for all clinical adverse events *MSP-22A-Open Disclosure Policy R1-04.03.19* which follows the open disclosure principles of the Open Disclosure Standard of the Australian Commission on Safety and Quality in Healthcare.

F. Prescribing

It is the policy of TEC that prescribing of antibiotics will be in accordance with Therapeutic Guidelines - Antibiotic & in accordance with the requirements of the NSQHSS V2– Antimicrobial Stewardship

G. Conduct of Procedures

Responsible VMO shall adopt TEC's policies and procedures in the conduct of patient treatment.
Histology specimens shall be sent for pathological examination whenever necessary
A copy of the pathologist's report shall be retained in the medical history.

H. Allocation of Theatre Sessions

Sessions shall be allocated to VMOs on an agreed basis depending on times that are suitable.

When a VMO wishes to cancel a session for any reason, it is required that 7 day's notice of such cancellation be given to TEC.

TEC reserves the right to make casual bookings for any session where there are no bookings 7 days ahead of any allocated session, or part of session not fully utilized.

I. Anaesthetics

The VMO who is to administer the anaesthetics shall ensure that he or she is fully acquainted with the patient's full medical history, has documented details of the medical history and is fully oriented to the emergency equipment and all policies and procedures of the Centre. Any patient referred to an Anaesthetist for a Pre-Anaesthetics Check (PAC) will be placed on that specialists list if deemed suitable to undergo a procedure at TEC.

J. Safety & Quality

VMOs are expected to contribute to the ongoing safety and quality improvement of TEC by participation in the safety and quality management program through peer review, collection of relevant clinical indicators and assistance with quality activities as required.

K. Confidentiality

The proceedings involved in granting appointment and clinical privileges to an Accredited Practitioner are confidential and are not to be disclosed outside the particular committee responsible for these functions in accordance with TEC By-Laws. Such confidentiality provisions shall also apply to any confidential information and to any committee or sub-committee of TEC.

L. Other Matters

TEC encourages VMOs to assist in other ways, including help in emergency cases, work on committees, participation in special programs and attendance at meetings where applicable.

7. REVIEW OF CLINICAL PRIVILEGES

The MAC may:

a) at any time, review the Clinical Privileges previously granted to an Accredited Practitioner including an assessment if necessary, of current fitness and confidence held in such an appointee concerning the continuation, amendment, suspension or revocation of those clinical privileges; or

b) require an independent review of the Clinical Privileges, practice or appointment of any Accredited Practitioner. The Report of such a review may include an assessment if necessary, of current fitness and confidence held in such an appointee and such a review may concern the continuation, amendment, suspension or revocation of Clinical Privileges. Such a review process shall result in a recommendation to the MAC who shall make a final determination in relation to the matter, subject to the provisions of By-Law

8. SUSPENSION

The MAC may suspend any Accredited Practitioner should the MAC believe:

- it is in the interests of patient care or safety
- the conduct of the Accredited Practitioner is such that it is unduly hindering the efficient operation of TEC at any time
- the conduct of the Accredited Practitioner is bringing TEC into disrepute.

Once a decision is made the Medical Director shall notify the Accredited Practitioner of their decision including reasons why the Clinical Privileges have been suspended or revoked.

9. TERMINATION OF APPOINTMENT

(a) An appointment shall be immediately terminated should an Accredited Practitioner cease to be registered by the relevant State Medical Board.

(b) An appointment may be terminated should an Accredited Practitioner become permanently incapable of performing his/her duties.

(c) An appointment shall be terminated should the Accredited Practitioner not be regarded by the MAC as having the appropriate Current Fitness to retain the Clinical Privileges granted or does not have confidence in the continued appointment of the Accredited Practitioner. The affected Accredited Practitioner shall have the rights of appeal contained in the By-Law

(d) The appointment of an Accredited Practitioner may at any time be suspended or terminated by MAC where:

- (i) the Accredited Practitioner fails to observe the terms and conditions of their appointment; or
- (ii) the Accredited Practitioner is adjudged guilty of professional misconduct or unprofessional conduct (however) described by the Medical Board; or
- (iii) an independent review has been conducted of the Accredited Practitioner pursuant to By-Law and following review of any such report of that review the Board does not have confidence in the continued appointment of the Accredited Practitioner.

(e) The appointment of an Accredited Practitioner shall be terminated as otherwise provided in the By-Laws.

(f) An Accredited Practitioner may resign his/her appointment after the expiry of one month after the giving of notice to TEC, unless agreed otherwise by MAC.

(g) MAC may suspend or terminate an appointment of an Accredited Practitioner should that practitioner be charged or convicted of a sex or violence offence or any offence in relation to the Accredited Practitioner's practice as a Medical Practitioner.

10. DISPUTES

Any dispute or difference which may arise as to the meaning or interpretation of these By-Laws or as to the powers of any committee or the validity of proceedings of any meeting shall be determined by the MAC.

11. DOCUMENT REVISION

MAC may from time to time make amendments to or vary or revoke these By-Laws but they shall be reviewed at least every three years.

12. ACKNOWLEDGEMENT AND AGREEMENT

I _____ do hereby acknowledge the Terms by which my rights to practice at the The Endoscopy Centre are initially approved and then governed on an ongoing basis and agree to practice in accordance with these By-laws.

Signed …… Date ……./……./…….