## I. PREAMBLE TO BY-LAWS AND INTERPRETATION

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

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

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 Officers (VMO's)for the purpose of granting clinical privileges or, context demanding, the accreditation of the hospital by an external organization.

*ANZCA:* Australian and New Zealand College of Anaesthetists

*Medical Director:* Medical Directors of Ivanhoe Endoscopy Centre

*Practitioner:* Medical Practitioners as registered by AHPRA 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.

## II. IVANHOE ENDOSCOPY CENTRE QUALITY POLICY

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

To provide quality, safe and caring service in a friendly and professional environment. In order to maintain certification with NSQHS, Ivanhoe Endoscopy Centre will strive to continually improve the services offered through the assessment of procedures, equipment and standards to provide state of the art services and patient care wherever possible.

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

- Accreditation or certification by an industry recognized independent accreditation organization (HDAA).

- Implementation of the National Safety and Quality Health Service Standards 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.
- Best practice documented clinical guidelines are available to all staff as per CG-Clinical Guidelines folder in 00-00 IVE Master Document System. VMO's and staff are responsible for ensuring they are up to date with guidelines. Read & Sign is scheduled for staff as per R-01-01 Quality Schedule.

## III. Credentialing of Visiting Practitioners

### 1. Categories of Visiting Practitioners

Each Person appointed as a Visiting Practitioner to the Hospital 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 Medical Directors, be for a period of three (3) years; ongoing appointment during this period is dependent on the furnishing to the hospital, of evidence of current medical registration and medical indemnity insurance (note medical registration can be used as evidence of indemnity cover)

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

The Medical Directors, or delegate 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 Directors or specialist nominated 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 HR-01-07 Application for Credentialing form:

a) The Medical Director or specialist nominated shall consider the application in the context of the centre's business plan and objectives and determine whether, pursuant to section 4(b), the application is to be given further consideration.
b) The Medical Directors, or delegate will contact the referees (initial appointment only) as per HR-01-09 Reference Check Form 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 inquires referred to in section 4(b), before the (MAC) Medical Advisory Committee for consideration (initial appointment only, subsequent re-credentialing is at the sole discretion of the Medical Director)
d) The Medical Advisory Committee that occurs as an agenda item at Management Review Meetings shall review the application and assess the applicant's qualifications, professional training, experience, capabilities involvement in continuing education, and ability to co-operate with the Medical Nursing Directors and other staff members.
e) 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.

**5. 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.

6. **Scope of Practice**.

Each VMO who has been approved by MAC and credentialing officer, will have their scope of practice defined in HR-01-07 Application for Credentialing. Approved VMO will receive a letter of offer outlining their scope of practice and responsibilities to IVE.

The request for any new procedures to be undertaken at Ivanhoe Endoscopy Centre will be presented to the Medical Directors by the requesting VMO. Before any new services can be implemented at Ivanhoe 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 Ivanhoe 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.