

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:

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

2. 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.
3. The implementation of appropriate credentialing systems and processes, including delineation of clinical management systems, including clinical practices guidelines, protocols or pathways as appropriate.
4. 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
5. A multi-disciplinary team approach to the provision of care and services that includes the patient, their families and carers and;
6. 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.
7. 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.

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- 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.

7. Urgent and Temporary Staffing

In the instance IVE urgently need senior medical practitioners temporarily, and in the event that the relevant committee cannot be immediately convened, the MAC (or the highest level of governance) should delegate the responsibility for undertaking credentialing and defining the scope of clinical practice to the director of medical services (or equivalent) on a temporary basis. Temporary credentialing and defining the scope of clinical practice decisions need to be followed as soon as practicable, in line with the formal processes undertaken by the credentialing and scope of clinical practice committee. Temporary credentialing should not exceed three months.

8. CORRECTIVE ACTION

ROUTINE CORRECTIVE ACTION

Whenever the activities or professional conduct of any Practitioner with clinical privileges or medical staff membership are detrimental to patient safety or to the delivery of adequate patient care, or are disruptive to the Hospital operation, corrective action against such a Practitioner may be initiated by any two officers of the medical staff, or by the Chief Executive Officer.

All requests for corrective action shall be in writing and submitted to the Chief Executive Officer. Upon receipt of the request for corrective action, the Chief Executive Officer will immediately notify the Medical Advisory Committee who will endeavour to resolve the problem through implementation of corrective action. Should this not be acceptable to the Practitioner?

The Chief Executive Officer shall require the Practitioner concerned to present their case within thirty (30) days of such notification. After this meeting, if the Management Review Committee recommends reducing or suspending medical staff membership and/or clinical privileges, then such recommendations will be made in writing by Chief Executive Officer. If the Practitioner fails to present their case, Medical Advisory Committee may take action as it sees fit.

Upon receipt of such recommendations and at the next regular scheduled meeting of Medical Advisory Committee pursuant to the recommendation shall be made. Notification of the decision shall be sent by the Chief Executive Officer to the Practitioner involved. If the decision adversely affects the medical staff membership or clinical privileges of the Practitioner involved, then the Practitioner shall have the right of appeal as outlined under of these By-laws.

SUMMARY SUSPENSION

The Medical Advisory Committee and Chief Executive Officer has the authority, whenever action must be taken immediately in the best interest of patient care in the Hospital, to suspend all or any portion of clinical privileges of a Practitioner and such summary suspension shall become effective immediately upon imposition.

Immediately upon the imposition of the summary suspension, the Chief Executive Officer shall have the authority to provide alternative medical cover for any patients of the suspended Practitioner still in the Hospital at the time of the suspension. Within thirty (30) days following such action, the Medical Advisory Committee will have a hearing to determine whether the affected Practitioner will be reinstated. If the action taken results in the Medical Advisory Committee to reduce or suspend medical staff membership and/or clinical privileges, then the affected Practitioner is to be advised in writing by the Chief Executive Officer of such recommendation. The affected Practitioner has the right of appeal

AUTOMATIC SUSPENSION

Automatic suspension of medical membership and/or clinical privileges shall be imposed to any member of the medical staff whose name has been removed or suspended from the Medical Register. Should the registration of the suspended member be reinstated during the period of time of the appointment to the medical staff, the Management Committee may reinstate their Hospital privileges.

9. RESIGNATION

A Visiting Medical Practitioner may resign at any time, and the Medical Advisory Board reserves the right to withdraw accreditation at any time upon giving at least 14 days' notice but without necessarily giving reasons for withdrawal of those privileges.

10. AMENDMENT OF BY-LAWS

These By-Laws and any Regulation made pursuant to them from time to time may be amended by submission of and proposed amendment to a meeting of the Medical Advisory Committee

11. MEDICAL ADVISORY COMMITTEE

Accountability

The Medical Advisory Committee acts in an advisory capacity of the facility.

Role and Responsibility

The committee nominees will:

- Make recommendations to the Board of Management on matters concerning clinical practice.
- Make recommendations regarding the appointment of visiting medical officers via the credentialing process, and withdrawal of those privileges should that be necessary.
- Advise on professional/ ethical issues on the part of all members of the medical staff and prescribe corrective measures if indicated.
- Support and advice on policies and procedures in order to meet medical legal requirements and current clinical practice.

Terms of reference

The two members of the Visiting Medical staff stay for 5 years. Then will encourage to other VMO to participate in this committee every 5 years.

Membership

- One members of the Visiting Medical Staff representing anaesthetists and proceduralists
- Chief Executive Officer/Director of Nursing
- One Consumer

Meeting

The MAC will meet quaterly, with further meetings being called if relevant issues arise. Informal communication will support the function of the committee (e.g. phone, email)

Chairman

A formal chairman is one of the two members of the Visiting Medical Staff.

Secretary

DON will maintain records of the committee