Chelsea Heights Day Surgery
& Endoscopy

'Patient Centred Care'

Chelsea Heights Day Surgery

and Endoscopy Pty Ltd

A.C.N. 145 463 494

Medical Staff Bylaws

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1. Mission Statement and Values

The Management and staff of Chelsea Heights Day Surgery is committed to:

- Providing the best available care to our patients,
- Providing the best available service to our doctors,
- Provide a competitive, affordable and safe health care service to our community,

Chelsea Heights Day Surgery is committed to continuously complying with our Management System which is based on ISO 9001, the international standard for Quality Management and the National Safety and Quality Health Service (NSQHS) Standards.

Chelsea Heights Day Surgery is also committed to continuously improving, through reviewing practice in response to established world's best practice, internal systems review and education.

Chelsea Heights Day Surgery has developed processes for planning to facilitate a transparent management system which involves all team members. The outcome of the planning process is a set of objectives reviewed and updated at least yearly.

2. Management Committee

1 Role of the Management Committee

The role of the Management Committee (Board) is to effectively represent and promote the interests of the Company's shareholders with a view to adding long-term value to the Company's shares and for the protection of shareholder funds.
The Board is accountable to the shareholders for the management of the Company's business and affairs, business performance, human resources management, information technology, work health and safety, and the safety and and quality of the services CHDS delivers and setting the organisation's quality improvement and risk management culture.

The ultimate responsibility for ensuring the integrity and effectiveness of the governance system rests with the governing body.

The role of the Board includes:

1.1 Strategic Direction

- A board's role is to oversee management
- Oversight of the strategic direction for the Company and endorsing the Company's strategy developed by the CEO;
- Decision making in relation to matters of a sensitive or extraordinary nature;
- Providing advice and counsel to management on a periodic and ad hoc basis; and
- Ensuring management implement the policies and decisions of the Board.

1.2 Governance

1.2.1 General

- Undertaking all reasonable measures to ensure best practice corporate governance;
- Monitoring the performance of the Chief Executive Officer (CEO) and approving senior management remuneration policies and practices; and
- Reporting to shareholders.

1.2.2 Compliance

- Undertaking all reasonable measures to ensure that appropriate compliance frameworks and control are in place and are operating effectively; and
- Approving and monitoring the effectiveness of and compliance with policies governing the operations of the Company.

1.2.3 Risk Management

- Monitoring and verifying that resources and processes are in place designed to achieve compliance with work health and safety laws;
- Monitoring the integrity of internal control and reporting systems; and

- Monitoring strategic risk management systems, including the review of processes for identifying areas of significant business risk, monitoring risk management policies and procedures, monitoring insurance coverage and oversight of internal controls and review of major assumptions used in the calculation of significant risk exposure.

1.3 Operating Performance

- Approving decisions concerning the capital of the Company, including capital restructures;
- Reviewing and approving the annual operating budget, the annual and half-yearly statutory financial statements and monitoring the financial results on an on-going basis; and
- Determining dividend policy and approving dividends.

1.4 Operational Development

- The appointment of the CEO and the approval of the succession plan
- Endorsing the appointment of the CEO's direct reports

2 Key Board Functions & Procedures

2.1 Board Composition

- The Board comprises of Owners/Directors and managers with a broad range of skills, expertise and experience
- From time to time the Board together with the Medical Advisory Committee (MAC) will review the skills, expertise and experience represented by members on the Board and determines whether the composition and mix of those skills, expertise and experience remain appropriate for the Company's strategy, subject to limits imposed by the Constitution.
- The appointment and removal of members (non-owners) is governed by the Company's Constitution. The Board is responsible for selecting and approving its own candidates to fill any casual vacancies that may arise on the Board with the assistance of the MAC.

2.2 Induction & ongoing support

- The Board has systems in place to ensure that all members receive the necessary support they require to perform their role effectively.
- Induction and orientation programs are in place for all newly appointed members, and continuing education and training is encouraged, whether provided externally or internally, on an 'as needs' basis to keep members informed regarding regulatory and market developments that significantly impact the Company's operations or their duties as members of the Board.
- The Board collectively has the right to seek independent professional advice as it sees fit. Each member individually has the right to seek independent professional advice, subject to the approval of the Chairman or Deputy Chairman.
- Members also have complete access to the senior management team. In addition to regular reports by senior management to the Board meetings, members may seek briefings from senior management on specific matters and are entitled to request additional information at any time when they consider it appropriate.

2.3 Director Independence

- The Board regularly reviews the independence of each Manager in light of information relevant to this assessment as disclosed by each member.
- The Board only considers members to exercise their judgement in an unfettered and independent manner.
- The Board does not believe that it should establish an arbitrary limit on tenure. While tenure limits can help to ensure that there are fresh ideas and viewpoints available to the Board, they hold the disadvantage of losing the contribution of members who have been able to develop, over a period of time, increasing insight in the Company and its operations and, therefore, an increasing contribution to the Board as a whole.
- Tenure is just one of the many factors that the Board takes into account when assessing the independence and ongoing contribution of a member in the context of the overall Board process.

2.4 Independent functioning of the Board

- To enhance the independent functioning of the Board, the Company
    - ensures that any conflicts of interest (or potential conflicts of interest) between the Company's major shareholder and the Company are identified and appropriately managed;
    - promote awareness of the importance of independent judgements in the Board's decision making;
    - provide leadership to the other independent directors and support them in presenting diverse perspectives on issues being considered by the Board; and

- Promote constructive interaction between members.

2.5 Board Meetings & Procedures

- The Board meets in accordance with their agreed schedule.
- The Board may also meet on other occasions between scheduled meetings to deal with specific matters as the need may arise.
- The Company's Constitution governs the regulation of Board meetings and procedures.
- Matters approved by the Board are executed by management and monitored by the Board in accordance with a business unit/specific project reporting timetable.

2.6 Delegations

2.6.1 Board Committees

The Board may from time to time establish Committees to streamline the discharge of its responsibilities.

The Board may also delegate specific functions to ad hoc Committees on an 'as needs' basis.

The following Committees have been established to operate under terms of reference approved by the Board:

- Medical Advisory Committee meeting as required
- Management Review Committee (MRC)

3. Medical Advisory Committee (MAC)

Membership

The Department of Health Victoria (Policy Handbook 2011) outlines that the Medical Advisory Committee should be composed of a core membership of:

1. medical practitioners from a range of clinical disciplines who have the necessary skills and experience to provide independent, high-quality advice including at least one from the relevant field
2. a member of senior management who will act as secretary
3. a member with high-level skills and experience in human resources management or have ready access at each meeting to a senior human resources professional with the relevant skills and experience.

The Medical Advisory Committee comprise of:

1. Medical Director/ CEO
3. Appointed Anaesthetist
4. Appointed Surgeon / Proceduralist
5. Director of Nursing
6 Others as required

The MAC is an integral part of the MRC Committee and as such issues relevant to the medical staff are discussed at each committee meeting

The MAC members are appointed and meets at least four times a year and more often if necessary.

FREQUENCY OF MEETING

Meeting Frequency:	At least four times a year
Chairperson:	Chair will be nominated at each meeting and will be an independent medical practitioner with no pecuniary interest in the health service.
Secretary:	Director of Nursing
Quorum:	At least three committee members must be present. Apologies should be directed to the Secretary by Midday before the meeting

Proceedings:

The Secretary will prepare an agenda in consultation with the Chairperson one week prior to the meeting

The Secretary will be responsible for taking minutes

Minutes are confirmed and signed by the Chairperson at each meeting

Any issues to do with CHDS are directed towards the DON/CEO and if possible rectified as soon as possible. If not, these will be discussed at the MRC if necessary

MAC also function as Credentialling Advisors. The MAC assists the MRC in fulfilling its fiduciary responsibilities in relation to CHDS'S strategic direction, corporate governance and ensuring best practice in the clinical services.

The MAC assist in the following areas:

1. To assist the MRC and the Board in overseeing the medical, professional and ethical activities of the Hospital, including Medical Practitioners appointments and re-appointments and the granting of privileges, accreditation and credentialing in accordance with the current standard for 'credentialing and defining the scope of practice of medical practitioners'.
2. To assist and advice the MRC and the Board on clinical services, procedures or other interventions to ensure these are provided by competent Medical Practitioners within environments that support the provision of safe, high quality health care services.
3. Promote efficient clinical processes and clinical education within the Hospital.
4. Advise the MRC & the Board on the safety, efficacy and role of new clinical services, procedures and other interventions, and assist to determine the financial and operational implications of these.
5. Assist in identifying health needs of the community and advising the MRC & Board of appropriate services which may be required to meet these needs.
6. Participate in the planning, development and implementation of quality programs including ensuring formal mechanisms for review of clinical management and outcomes are in accordance with the requirements of these By-laws
7. Assisting the MRC & the Board as required in relation to succession plans, making recommendations and assisting in the performance evaluation of its committees.

4. Management Review Committee

- The MRC oversees the overall management of CHDS's business and affairs, and as such is responsible for the overall strategy, governance and performance of CHDS. The MRC reports to the Board for final endorsement. The MRC is the highest governance at CHDS and has the final say in any decision-making at CHDS.
- Management Review is held at least twice a year
- It aims to assess progress against Hospital objectives, effectiveness and suitability of the Hospital systems. This is in accordance with the AS/NZS ISO 9001 quality management systems, standard 9.3 Management review and the requirements of the NSQHSS Standard 1. This review examines the quality management system and determines if it meets the conditions set by these standards. The review will serve as a guide in making future determinations towards the effectiveness and direction of the quality management system. This shall include assessing opportunities for improvement and the need for changes to the quality management system, including the quality policy and quality objectives. The quality management system may need to be modified due to changes that have or are expected to take place in the organization, facilities, staffing, equipment, activities or workload.
- The MRC members comprises of the CEO/MD, Business Manager/ DON, Office Manager, Accounts Manager & Pharmacist. Other staff may be invited as appropriate.
- All Accredited Medical Practitioners (MPs) appointed to CHDS will be referred to the MAC/ MRC should there be any issues or discussions to be conveyed. Any urgent problems or concerns encountered by individual MP can be expressed by discussing directly with the CEO/DON, phone, emails and this will be noted on the IIIR form (F-22-02).
- Appointed MPs at CHDS will form part of the Medical Advisory Committee (MAC) and provide supporting input into the successful management of CHDS. They will be invited to the MRC if there are any irresolvable issues.
- Items reviewed include key development in the day surgery, key performance: IIIR, audits, minor issues, health department and external audits, internal audits: performance, plan, feedback, supplier issues, staff training issues, OHS issues, review of medical practitioners applications, any medical issues, privacy and confidentiality, emergencies issues, equipment issues, any changes to regulations or standards and tabling the business plan and recording against each objective the percentage completed.
- The scope and effectiveness of external audit, the appointment, performance and remuneration of external auditors
- Reviewing risk management policies and disclosure requirements relating to risk management;

- Reviewing the effectiveness of the Risk Management Framework, including the Company's risk management, internal compliance and control policies and procedures, in identifying and managing risks and controlling internal processes.
- Responsible for oversight of the Company's accreditation programs and continuous quality improvement systems, occupational health and safety policies and the review of clinical and infection control procedures.
- Review the process designed to verify the credentials of medical practitioners who use the hospital's facilities, and review reports from the MAC.

5. CHDS Staff meetings

- Staff meeting is held as the need arises and aims to improve the clinical services by ensuring safety and quality requirements at the Day Hospital
- The members comprise of the DON, Administrative staff, nursing staff and other staff may be invited as appropriate.
- Items discussed include IIIR reports, internal audits, administrative issues, reports of health department and external audits, staff training, OHS issues, any clinical issues, privacy and confidentiality issues, emergencies issues, equipment issues, any changes to regulations and others as appropriate

6. Senior Management Staff

CEO & Management Delegations

- The Board delegates the responsibility for the day-to-day management of the Hospital to the CEO, who is assisted by the Director of Nursing (DON).
- The CEO must consult with the MRC on any matters, which the CEO considers are of such a sensitive, extraordinary or strategic nature as to warrant the attention of the Board regardless of value.
- The authorisation thresholds for the control of expenditure and capital commitments have been established and defined in the Company's policy on Delegated Authorities
- Special and routine capex proposals, which have investment or expenditure initiatives with direct or indirect exposure to the Company, above the CEO's approval threshold as provided in the Delegated Authorities policy, must be submitted to the Board for approval.
- The CEO is responsible to the Board for the overall development of strategy, management and performance of the Company. The CEO manages the organisation in accordance with the strategic business plans and policies approved by the Board to achieve the agreed goals

Director of Nursing (DON)

- Responsible for the day to day operational and clinical functioning of CHDS.
- Ensures that the Day Surgery is managed according to current standards and meets all statutory requirements.
- As part of the management team the DON will be actively developing the work ethic, standards of practice, and ultimately the clinical excellence and reputation of the hospital.
- Co-ordinate the priorities of the Day Surgery and set the Strategic direction for this service in collaboration with the CEO / Medical Director
- Providing support for the Nursing staff, Admin staff and other Hospital staff
- And others as according to the DON position description in the areas of clinical service and patient care, teamwork and leadership, quality management , risk management and OHS

7. Medical Director (MD)

- Responsible for the overall management of medical practitioners
- Ensures that systems for credentialing and defining scope of clinical practice are effective.
- Must have the requisite qualifications, skills and knowledge to assist in the credentialing and defining the scope of clinical practice at CHDS
- CHDS should have ready access to MD support on a regular and as-needed basis.
- The MD should have their credentials and scope of clinical practice defined through the usual organizational process.

8. Appointment of Medical Practitioner

Linking scope of clinical practice to the role of CHDS

- The clinical needs of CHDS determine the core competencies required of its practitioners and provide the parameters in which the scope of clinical practice should be defined.
- The range of services is determined by service planning decisions and capability-based planning frameworks. As planning frameworks are developed at CHDS, they are considered in the scope of clinical practice. This will help identify minimum requirements and expected competencies of clinicians

Initial appointment for Medical Practitioners

- All doctors wishing to make an application should complete the F-06-01- NEW CREDENTIALLING MED STAFF form and attach a CV with at least 2 referees named, a copy of all qualifications, current medical registration and professional indemnity insurance details.
- The applicant will be requested to send the F-06-02-MP REFEREE REPORT to their referees to complete.
- All completed forms should be sent, along with all supporting documents, to the CEO for consideration.
- The CEO assesses the application against the need and capability of CHDS and establish suitability
- The CEO will then notify the MAC that a new application has been received and will forward a copy to them
- The MAC will review the application and supporting documents, verify basic credentials, review references
- Depending on the position applied for, the MAC, preferably within the specialty being applied for, who are independent of the applicant, with no conflict of interest, and who can attest to the applicant's professional performance within the previous three years. References must be verified verbally. 2 referee reports (F-06-02-MP REFEREE REPORT) have to be completed.
- If CHDS have no such discipline (for eg. Ophthalmologist), the Medical Director will proceed to check the references through colleagues in the same field
- The application and supporting documents will be presented at the MAC where the file will be reviewed, credentials and professional references verified and the scope of clinical practice determined.
- The MAC will then make the recommendation for endorsement by the Board if the application is in order

Appointment

- The MRC will review the recommendation and make a decision on granting of visiting rights.
- The applicant will be notified by the CEO as soon as possible after the decision has been made
- The appointment will be confirmed in writing - F-06-04-LETTER OF APPROVAL.
- A copy of the Medical Bylaws will be attached to the letter of appointment - F-06-08-Medical Staff Bylaws
- The MP must agree to the terms and conditions outlined in the Medical Bylaws for consideration of appointment.
- Initial appointment, annual credential review and re-credentialling process is in accordance with the requirements as stated in Appendix 6 of the Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services – a policy handbook

Re-appointment – Every Three years

- The DON/CEO will at least 90 days prior to expiration date of the present appointment for each visiting practitioner; provide the practitioner with an application for re-appointment F-06-05-RE-CREDENTIALLING MED STAFF.
- Upon receipt and verification of information contained in the form, the CEO or DON will forward the application to the MAC for review and approval recommendation
- This is then forward to the MRC and endorsed by the BOM who will then grant the visiting rights

License to Practice, Professional Indemnity Insurance & CPD

- All MP's must forward copies of their Professional Indemnity Insurance to the Administration staff on an annual basis. Their registration can be downloaded from the AHPRA website.
- The Medical Board of Australia requires that all medical practitioners participate in regular continuing professional development (CPD) that is relevant to their scope of practice in order to maintain, develop, update and enhance their knowledge, skills and performance to ensure they deliver appropriate and safe care.

- While medical practitioners must confirm their participation in CPD as part of their annual registration renewal, AHPRA does not currently sight evidence of CPD. Presentation of CPD documentation (for example, a copy of a college certificate) therefore form part of CHDSs regular credentialling and scope of clinical practice process at both initial application stage and when re-credentialling
- The Administration staff will maintain the personnel files
- The DON will audits the personnel files annually to ensure all requirements are upto date.
- Administration staff will follow up MP's who's information is not complete and updated, with a IIIR and if necessary escalate the non-compliant files to the Board of Management Committee

Appeals process

- An appeals process can be made available if necessary and managed independently of the credentialling and scope of practice committee and the appointments committee. The appeals process will allow for reconsideration of any decision and for new information to be presented.
- The medical practitioner who has had their request for scope of practice denied, withheld or varied from the original request has a right to appeal the decision.
- The appeal must be lodged within seven days of receipt of the decision.

9. Tenure

The tenure of Accreditation shall be for 3 years to the age of 65 and for 1 year thereafter or as otherwise determined by the MAC, MRC & Management Committee.

All applications for appointment to the Medical Staff shall be made to the MAC, MRC & Management Committee through the MD, CEO or DON.

The MRC retains the absolute discretion to take any action it deems to be in the best interests of the Hospital and the decision of the MRC shall be final.

The MD or in his absence the CEO is authorised to act for and on behalf of the MRC in granting interim Accreditation rights and in suspending Accreditation rights without prior notice until the next meeting of the Committees at which time ratification or review of such action can take place.

10. Responsibilities of Accredited Medical Practitioner

The responsible Accredited Medical Practitioner shall be -

- the Accredited Medical Practitioner who arranged the admission of the patient to the hospital; or
- where no Accredited Medical Practitioner arranged such admission the Accredited Medical Practitioner who has assumed responsibility for the medical care and treatment of the patient; or
- the Accredited Medical Practitioner as a result of a change notified to the MD by both Practitioners.

Assistants, Locums and Non-Accredited Consultants

The Responsible Medical Practitioner may obtain assistance from Medical Practitioners who are not Accredited Medical Practitioners. This assistance may take the form of consultation, locums, or the provision of special diagnostic, surgical or therapeutic procedures, but the primary responsibility for the care and treatment of the patient shall remain with the patient's Responsible Medical Practitioner.
Should an Accredited Practitioner wish to appoint a locum practitioner to cover a period of absence, the Accredited Practitioner shall advise the CEO/MD in adequate time. This is to enable the MAC time to consider the appointment of that practitioner as a locum practitioner. Such appointment may be on a temporary basis for up to six months. The final decision shall only be made by the MRC and shall always be subject to the requirements of the By-Laws and any other conditions considered appropriate by the MRC/MAC from time to time.

CHDS reserves the right to refuse access to any Medical Practitioner who is not an Accredited Medical Practitioner.

Inability to Contact Responsible Accredited Medical Practitioner

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 Responsible Accredited Medical Practitioner, every reasonable effort will be made to communicate with the Responsible Accredited Medical Practitioner with regard to the situation and consult with him as to the care and treatment of the patient. However, if Responsible Accredited Medical

Practitioner cannot be contacted, the Hospital has the right to take whatever action it considers necessary in the interest of the patient. This may include the calling of another accredited medical practitioner to care for the patient, or the transfer of the patient to hospital. In either case the Responsible Accredited Medical Practitioner will be advised of the action as soon as possible.

11. Consent for Medical Treatment

The Hospital provides facilities and nursing care for the treatment and management of patients of Accredited Medical Practitioners. It is the responsibility of the Responsible Accredited Medical Practitioner to ensure that the consent of his/her patients to the nature and form of all treatment is obtained.

12. Pre Admission Advise

The Responsible Accredited Medical Practitioner shall provide details of all patients to be admitted under his care to the Administrative staff.

13. Medical Record Documentation

During the course of a patient's treatment at the Centre, 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 Responsible Accredited Medical Practitioner directing such treatment.

On conclusion of treatment a procedure report shall be written by the Responsible Accredited Medical Practitioner containing a description of the procedure performed and all relevant findings.

The nursing staff must be provided with clear written instructions regarding discharge of patients and the arrangements for follow-up.

14. Disclosure of Patient Information

CHDS is committed to the protection of personal privacy of our patients, staff and other clients. Our personal privacy policy adheres to the Australian Privacy Principles (APPs) of the Victorian Health Records Act 2001. The APP outlines how all private health service providers must handle, use and manage personal information.

The Privacy Act 1988 (Privacy Act) regulates how personal information is handled. The Privacy Act defines personal information as:

…information or an opinion, whether true or not, and whether recorded in a material form or not, about an identified individual, or an individual who is reasonably identifiable.

The APP can be obtained through the website of the Office of the Australian Information Commissioner (OAIC) https://www.oaic.gov.au/privacy-law/privacy-act/

15. Open Disclosure of Adverse Patient Events

CHDS has a policy of open disclosure for all clinical adverse events and follows the open disclosure principles of the Open Disclosure Standard Australian Commission on Safety and Quality in Healthcare.

16. Prescribing

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

17. Conduct of Procedures

Responsible Accredited Medical Practitioner shall adopt the Hospital's policies and procedures in the conduct of patient treatment at the Hospital.
Histology specimens shall be sent for pathological examination whenever necessary
A copy of the pathologists report shall be retained in the Hospital's medical history.

18. Allocation of Theatre Sessions

Sessions shall be allocated to Responsible Accredited Medical Practitioners on an agreed basis depending on times that are suitable.

The patient's name, provisional diagnosis, the nature of procedure to be performed, the patient's age, telephone number, health insurance details etc. shall be notified to the Administrative Staff as early as possible prior to the session.

When a Responsible Accredited Medical Practitioner wishes to cancel a session for any reason, it is required that 7 days notice of such cancellation be given to the Hospital.

The Hospital 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.

19. Anaesthetics

The Responsible Accredited Medical Practitioner who is to administer the anaesthetic 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 polices and procedures of the Centre.

20. Quality

Responsible Accredited Medical Practitioner are expected contribute to the ongoing quality improvement of the Hospital by participation in the quality management program through peer review , collection of relevant clinical indicators and assistance with quality activities as required.

21 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 CHDS By-Laws. Such confidentiality provisions shall also apply to any confidential information and to any committee or sub-committee of CHDS.

22. Other Matters

The Hospital encourages Responsible Accredited Medical Practitioners to assist the Hospital in other ways, including help in emergency cases, work on committees, participation in special programs and attendance at meetings.

23. Introduction of New Clinical Services, Procedures & Interventions

These are defined as new services, procedures or interventions that are being introduced into CHDS for the first time.

The MRC will determine whether such services should be introduced following recommendations made by MAC & CEO/ DON based on considerations including safety, cost, support services and staff training. Such decisions are informed by service planning decisions and capability-based planning.

Where new services are introduced, medical practitioners wishing to include such services within their scope of clinical practice must formally undergo appropriate credentialling and scope of clinical practice processes specifically for that service

24. Provisional Appointment/ Temporary Credentialling

The MAC with the CEO may approve provisional appointments as an Accredited Practitioner and may grant Clinical Privileges to such provisionally appointed Accredited Practitioners. Clinical Privileges granted under this By-Law shall remain in force until the determination by the MRC & Board.

Urgent staffing situations

- When CHDS need clinicians urgently, the MRC will delegate to the MAC the responsibility of undertaking credentialling and defining the scope of clinical practice on an urgent basis.
- Urgent credentialling and defining the scope of clinical practice decisions need to be followed up as soon as practicable by the formal processes undertaken by the established MRC. The timeframe for undertaking the formal process is consistent with the by-laws and would generally occur within six months.
- Verbal confirmation of the medical practitioner's competence, performance and appropriateness for the position is required from at least one professional referee.

Emergency clinical situations

- Policies and processes related to credentialling, scope of clinical practice and appointment also include provision for credentialled medical practitioners to administer necessary treatment outside their authorised scope of clinical practice in emergency situations.
- This may be where a patient may be at risk of serious harm if treatment is not provided and no medical practitioner with an appropriate authorised scope of clinical practice is available and where more appropriate options for alternative treatment or transfer are also not available

25. Amendment of Privileges

- Any Accredited Practitioner, at any time, may make application in writing for amendment of his/her Clinical Privileges.
- The CEO shall cause any such application to be forwarded to the MAC
- The MAC shall give such application appropriate consideration and make a recommendation to the MRC as to the amendments sought.
- MRC shall then consider the relevant recommendations concerning the application and, on reaching its decision, it shall within fourteen days, communicate its decision to the Accredited Practitioner within seven days.

26. Review of Clinical Privileges

MAC / MRC / CEO may:

- 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
- 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 MRC who shall make a final determination in relation to the matter, subject to the provisions of By-Law

27. Suspension

The MRC/MAC may suspend any Accredited Practitioner should the MRC/MAC believes

- 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 CHDS at any time
- the conduct of the Accredited Practitioner is bringing CHDS into disrepute.

The MAC will advice the MRC. Once a decision is made the MRC will inform the CEO who shall notify the Accredited Practitioner of their decision including reasons why the Clinical Privileges have been suspended or revoked.

28. 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 / MRC 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 MRC 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 MRC 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 CHDS, unless agreed otherwise by MAC/ MRC.

(g) MRC 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.

29. 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 MRC.

30 Document Revision

MRC may after due consultation with MAC from time to time make, vary or revoke these By-Laws but they shall be reviewed at least every three years.