BURNSIDE HOSPITAL

ACCREDITED PRACTITIONER BY LAWS

The Burnside War Memorial Hospital Inc.

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1. INTRODUCTION

Burnside War Memorial Hospital (Burnside Hospital **(BH)**) is a not-for profit community-based private hospital. It is governed by a Board of Directors **(BOD)**, with the Chief Executive Officer **(CEO)** being responsible to the BOD for the overall management of the hospital.

BHs mission is to honour the intent of the Deed of Gift of Mr Otto von Rieben by successfully providing safe, contemporary care for every patient, every time, in current well equipped facilities.

BH is committed to and seeks to promote the key values of respect for the individual, teamwork and high quality service which are fundamental to the hospital achieving our primary goal of excellence in patient care and associated services.

We value:

- Observing the rights of our patients, focussing on respect for their privacy, dignity and individual needs;
- The professional relationship with our visiting clinicians;
- Providing high quality care and services;
- Delivering service excellence through a collegial approach;
- Managing available resources effectively and efficiently;
- The right of staff to enjoy a safe and healthy workplace;
- The continuing education and development of individuals.

2. PREAMBLE

The BOD of BH has the responsibility to ensure the competency and facilitate the performance of all professional health care providers practising within BH. All such providers shall have their credentials assessed prior to Accreditation ensuring that only those providers who are suitable and who have the relevant credentials will be considered for Accreditation.

Accredited Medical and Dental Practitioners are responsible for the quality of medical and dental care at BH. The following By-laws establish an appropriate process for the assessment of applications and granting of Clinical Privileges for all professional health care providers and the ongoing revalidation/review of these Clinical Privileges as required. They set out the basis upon which Accredited Practitioners may be permitted to treat patients at BH and are designed to protect the interests of BH, its patients and Accredited Practitioners.

As detailed in Part 8 Accredited Practitioners are required to provide documented evidence of qualifications including relevant board registration, relevant experience and current competence in the delivery of professional health care services for which Clinical Privileges are requested. Details of current registration with the Australian Health Practitioner Regulation Agency (AHPRA) and professional indemnity insurance are pre-requisites to an application being processed. Applications for Scope of Practice must be accompanied by documented evidence of competence to practice at the level sought. Such applications shall be approved in accord with the current, relevant specialist medical college(s) and/or Medical or Dental Board of Australia Standards which have been formally adopted by the BOD on the advice of the Medical Executive Committee (MEC) and/or Clinical Privileges Review Committee (CPRC).

The Accreditation process for visiting practitioners will consider the individual credentials of the practitioner and reflect on the organisational capabilities and requirements of BH.

The CPRC is a sub-committee of the BOD whose function is to review new and renewal applications for Medical and Dental Practitioners and Allied Health Professional Clinical Privileges at BH. The CPRC is also responsible for monitoring and reviewing the professional performance of Accredited Practitioners and Allied Health Professionals.

Individuals involved in the Accreditation process through the CPRC shall be indemnified by BH for their actions to enable the role to be performed responsibly without constraints imposed by potential legal action.

BH has established systems for the early identification and management of compromised performance including that related to incompetent and impaired practitioners.

The BOD and the CPRC have the responsibility to oversee and monitor the diligent application of these By-laws in the best interests of BH.

BH seeks to ensure that effective working relations are established and maintained with all Accredited Practitioners having regard for the needs of both parties. The following issues are considered integral to BH being able to sustain its business in accord with patient and staff safety considerations, effective risk management, Hospital Preferred Provider agreements with private health insurers and the sustainable use of its resources. The active cooperation of all Accredited Practitioners will assist BH in achieving its clinical and business goals and ensure the provision of safe clinical care and a safe working environment and systems of work for all personnel.

3. DEFINITIONS

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

- The specified Accreditation Category where applicable and Scope of Clinical Practice (Attachment 1);
- Any specified conditions;
- The Code of Conduct (Attachment 2);
- The policies and procedures of BH;
- These By-laws.

Accreditation Category means one or more of the designated categories of an Accredited Practitioner as set out in Attachment 1.

Accredited Practitioner means a Medical Practitioner or Dental Practitioner previously known as a Visiting Medical Officer (VMO) authorised to treat patients at BH in accordance with a specified Accreditation Category and Scope of Clinical Practice.

Act means all relevant legislation applicable to and governing:

- BH and its operation;
- The support services, staff profile, minimum standards and other requirements to be met in BH;
- The health services provided by and the conduct of the Accredited Practitioner.

Adverse Finding means a decision which is unfavourable to the practitioner, but does not include a caution imposed by a National Board under the Health Practitioner Regulation National Law (South Australia) Act 2010.

AHPRA means the Australian Health Practitioner Regulation Agency established under the Health Practitioner Regulation National Law Act 2009 which came into effect on 1 July 2010.

Application Form means the form approved by BH from time to time for use by a medical or dental practitioner to apply for Accreditation at BH.

Board of Directors (BOD) means the Board of Directors, the governing body of BH.

Burnside War Memorial Hospital Constitution means the constitution in force under which BH operates to provide health care services.

Burnside War Memorial Hospital Inc. (BH) means Burnside Hospital.

By-laws means these By-laws, including any schedules, as amended from time to time.

Chief Executive Officer (CEO) means the person appointed by the BOD, or their delegate approved by the BOD, to act on its behalf in the overall management of BH.

Child Protection Reportable Conduct means any serious offence against children, as envisaged by the *Children's Protection Act (SA) 1993*, including but not limited to neglect, assault or sexual offence committed against, with or in the presence of a child.

Code of Conduct means the BH Code of Conduct. (Attachment 2, ATTAC-022)

Clinical Privileges means the specific medical services, surgical or dental procedures permitted to be undertaken by Accredited Practitioners at BH within defined limits and a specified Scope of Clinical Practice.

Clinical Privileges Review Committee (CPRC) means a sub-committee of the BOD that has multidisciplinary membership, established by BH in accordance with these By-laws to perform the following functions:

- Accreditation and Credentialing in accordance with these By-laws;
- Defining the scope of clinical practice in accordance with these By-laws;
- Appeals in accordance with these By-laws.

Clinical Review Committee (CRC) is a sub-committee of the Medical Executive Committee that is protected under part 7 of the SA Healthcare Act, 2008, Protected Committees for Safety and Quality.

Competence is the application of knowledge and skills in interpersonal relations, decision-making and performance consistent with the Accredited Practitioner's practice role.

Credentials means the qualifications, professional training, clinical experience, current registration and status, indemnity insurance, training and experience that contribute to the competence, performance and professional suitability to provide safe, high-quality health care services at BH.

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

Current Fitness is the current fitness required of an Accredited Practitioner 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 person's physical or mental capacity to practice medicine or dentistry and carry out the Scope of Clinical Practice sought or currently held. Habitual drunkenness or addiction to deleterious drugs is considered to be a physical or mental disorder.

DCO means the Director Clinical Operations.

Dental Practitioner means a person registered as a dentist by the Dental Board of Australia governed by AHPRA pursuant to the *Health Practitioner Regulation National Law (SA) Act 2010.*

Health Insurer refers to the private health insurance companies including the Department of Veterans Affairs with which BH may or may not have signed a Hospital Preferred Provider Agreement.

Locum is a visiting practitioner who has been granted a temporary Accreditation to BH and who may exercise clinical privileges in accord with the conditions of their Accreditation.

Medical Executive Committee hereinafter known as the MEC is a subcommittee of the BOD with multidisciplinary membership appointed by the BOD in accord with its approved terms of reference.

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 (SA) Act 2010.*

New Clinical Services, Procedures, or Other Interventions (including medical or surgical procedures and the use of prostheses and implantable devices or diagnostic procedures) means those 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 BH, as well as variations to an existing procedure or treatment where a new device or item of equipment is introduced.

Notifiable Conduct has the same meaning prescribed to that term in the *Health Practitioner Regulation National Law (SA) Act 2010.*

Organisational Capability means BH'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.

Prohibited Person means a person prohibited under the Children's Protection Act (SA) 1993, from being employed or engaged in a child related area of activity.

Performance describes how the output of a process conforms to requirements and expectations and suggests how well an individual, process or team is operating.

Professional Indemnity Insurance means the insurance of an Accredited Practitioner taken out in accordance with By-law 6.14.

Professional Misconduct has the same meaning prescribed to that term in the *Health Practitioner Regulation National Law (SA) Act 2010.*

Re-accreditation means the formal process used to reconfirm 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 for the purpose of forming a view about their ongoing competence, performance and professional suitability to provide safe, high-quality health care services at BH.

Scope of Clinical Practice means specific medical services or procedures permitted to be undertaken by a credentialed practitioner. Defining the Scope of Clinical Practice follows on from Credentialing and involves delineating the extent of an Accredited Practitioners clinical practice based on the individual's credentials, competence, performance and professional suitability and the needs and the capability of the organisation to support the Accredited Practitioners Scope of Clinical Practice.

Surgical Assistant means an individual who assists the Accredited Practitioner in the operating theatre.

Unprofessional Conduct has the same meaning prescribed to that term in the *Health Practitioner Regulation National Law (SA) Act 2010.*

Unsatisfactory Professional Performance has the same meaning prescribed to that term in the *Health Practitioner Regulation National Law (SA) Act 2010.*

Visiting Intensivist shall mean an accredited practitioner who can be contacted by BH and other Accredited Practitioners to provide an intensive care medicine service to their patients.

VMO shall mean Visiting Medical Officer including visiting dentists granted Clinical Privileges at BH. VMO shall also be taken to mean *Accredited Practitioner or visiting clinician.* The term VMO may appear in the separate attachments to the By-laws.

4. PURPOSE

The purpose of these By-Laws is to set out:

- The processes and requirements for the Accreditation of practitioners as a pre-condition to any permission to admit patients and to care for and treat patients at BH; and
- The conditions upon which Accreditation may be granted and with which all Accredited Practitioners are expected to comply with a view to ensuring the delivery of high quality care to patients at BH.

The Accreditation of a practitioner and granting of Clinical Privileges is a necessary pre-condition to the practitioner being permitted to treat patients at BH.

Accreditation and the granting of Clinical Privileges does not confer any right or entitlement to, guarantee or expectation of, any of the following (the grant, allocation, variation or cessation of which remains entirely at the discretion of BH):

- permission to admit or treat patients at BH;
- any availability of bed access;
- any allocation of operating session time.

5. PRIVACY AND CONFIDENTIALITY

5.1 Privacy

Accredited Practitioners will manage, and assist BH to manage, all matters related to the privacy of information in compliance with the Australian Privacy Principles established by the Privacy Act 1988 (Cth) and in compliance with the various statutes governing the privacy of health information.

The privacy and confidentiality requirements of these By-laws continue with full force and effect after the Accredited Practitioner ceases to hold Accreditation at BH.

5.2 Accredited Practitioners and Confidentiality

Subject to By-law 5.1, every Accredited Practitioner must keep confidential the following information:

(a) Business information concerning BH;

(b) 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.

5.3 Committees

All information made available to, or disclosed in the context of a committee of BH will be treated as confidential 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 proceedings for the Accreditation including designation of Scope of Clinical Practice of the Accredited Practitioner;

(b) The proceedings for any change to the Scope of Clinical Practice of the Accredited Practitioner.

5.4 What confidentiality means

The confidentiality requirements of By-laws 5.1, 5.2 and 5.3 prohibit the recipient of the confidential information from using or disclosing it for any unauthorised purpose, which includes copying it, reproducing it or making it public.

5.5 When confidentiality exceptions apply

The confidentiality requirements of By-laws 5.1, 5.2 and 5.3 do not apply in the following circumstances:

(a) Where disclosure is required or authorised by law;

(b) Where use and/or disclosure of personal information is consistent with By-law 5.1;

(c) Where disclosure is required by a regulatory body in connection with the Accredited Practitioner;

(d) Where the person benefitting from the confidentiality consents to the disclosure or waives the confidentiality;

(e) Where disclosure is required in order to perform a requirement of these By-laws.

6. TERMS AND CONDITIONS OF ACCREDITATION

These By-laws prescribe the terms and conditions upon which Accredited Practitioners may be permitted to practice at BH and with which they are required to comply whilst practicing at BH and must be strictly adhered to.

The following conditions are for the conduct of the Accredited Practitioners to BH. They reflect what is regarded as being current acceptable medical/dental practice.

These By-laws and other documents referred to in these By-laws which are applicable to Accredited Practitioners and with which Accredited Practitioners are required to comply (Governing Documents) are made available to applicants for Accreditation and Accredited Practitioners via BH's website: www.burnsidehospital.asn.au under the *For Health Professionals Section – Becoming a Credentialed Medical Officer*.

Although basic ethical considerations do not alter, the By-laws and other Governing Documents can be amended from time to time at the discretion of BH, to take account of changes in circumstances and policy.

It is the responsibility of all Accredited Practitioners to remain familiar with the Governing Documents, as amended from time to time.

It is expected as a matter of course that all Accredited Practitioners will adhere to the highest principles of medical ethics in their relations with their patients, their colleagues and BH. Ethics enunciated and supported by the Australian Medical Association and the specialist Medical Colleges will be accepted as the minimum standard.

6.1 Conditions applicable to all Accredited Practitioner Accreditations

Accreditation as an Accredited Practitioner at BH is conditional on the Accredited Practitioner complying with all matters set out in this By-law 6.

6.2 Accredited Practitioner requirements

Accredited Practitioners must:

(a) Comply with their authorised Scope of Clinical Practice;

(b) Comply with the BH Code of Conduct as it applies to Accredited Practitioners (Attachment 3);

(c) Comply with all applicable legislation and general law;

(d) Comply with these By-laws, rules, policies and procedures of BH.

(e) Maintain their registration with AHPRA and furnish annually to BH 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 new or varied conditions, suspension or termination);

(f) If operating session time and/or resources have been requested by the Accredited Practitioner and allocated, utilise the session time and resources effectively. (Refer also to By-law 6.9 Conduct of Surgery).

(g) Observe all requests made by BH with regard to his or her conduct in BH with regard to the provision of services with BH;

(h) Adhere to the generally accepted ethics of medical or dental practice, including the ethical codes and codes of good medical practice of the Australian Medical Association and the Australian Dental Association (as applicable) and all relevant standards or guides issued by the Medical and Dental Boards of Australia as issued from time to time in relation to his or her colleagues, BH employees and patients;

(i) Adhere to general conditions of clinical practice applicable to BH, including compliance with the accreditation standards of the National Safety and Quality Health Service Standards 2012 and/or such other accreditation body nominated by BH;

(j) Observe the rules and practices of BH in relation to the consent, admission, discharge and accommodation of patients;

(k) Not treat a member of their immediate family at BH;

(l) Participate actively and cooperate in quality related activities such as quality assurance, clinical review and risk reduction as required to minimise the risk of harm to patients and maximise the patient's clinical outcomes;

(m) Participate in craft group structures which may be established;

(n) Seek relevant approvals from the relevant committee and, where applicable, the relevant research and ethics committee in regard to any research, experimental or innovative treatments, including any new or revised technology (see By-laws 6.25 & 6.26);

(o) Not purport to represent BH in any circumstances, including the use of BH letterhead unless with the express written permission of the CEO;

(p) Subject to the requirement of relevant laws, keep confidential details of all information which comes to his or her knowledge concerning patients, clinical practice, quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services - refer By-law 5;

(q) Be available to and to participate in the BH accreditation program with the Australian Council on Healthcare Standards (ACHS). Such participation includes, but is not limited to, the provision to BH of annual evaluations of the quality of the service provided confirmed in written feedback from patients, referring doctors and BH clinical and administrative staff.

Provided always that whether permission is granted to any Accredited Practitioner to treat patients at BH and the allocation of bed access or operating session time is at the discretion of BH and the extent of any permission, allocation, variation, re-allocation or withdrawal of these remains at the discretion of BH at all times. Without limiting this discretion BH will endeavour, where practical, to provide advanced notice of any changes affecting an Accredited Practitioner.

6.3 Responsibility for Patient Management

Accredited Practitioners must:

(a) Obtain full and informed written patient consent prior to a procedure being performed as per By-law 6.8;

(b) Admit to BH only those patients who, in the opinion of the CEO/DCO, can be properly managed within the organisational capability of BH. The CEO/DCO will advise Accredited Practitioners from time to time of any categories of patients who are considered inappropriate for admission to BH (Burnside Hospital Admission Exclusion Criteria, Attachment 6);

(c) Observe the rules and requirements applicable to BH with respect to the admission of patients (See By-law 6.4);

(d) Accept full responsibility for his or her patients from admission until discharge, or until the care of the patient is transferred to another Accredited Practitioner;

(e) Be available for contact at all times when that Accredited Practitioner has a patient admitted to the hospital,

or must nominate another Accredited Practitioner, who is acceptable to and approved by BH, with equivalent Accreditation to continue the care of their patient during their absence;

(f) Provide prior notification/referral to the BH Visiting Intensivist of the possibility of a patient requiring admission to the BH High Dependency Unit to ensure bed allocation and that patients receive required clinical care in a timely manner;

(g) Note the details of a transfer of care to another Accredited Practitioner in the patient's medical record and communicate the transfer to the Clinical Manager or other responsible nurse/midwife staff member;

(h) Attend patients in a timely manner, using their best endeavours to attend promptly after being requested to do so, or being available by telephone in a timely manner to assist the nursing/midwifery staff in relation to the Accredited Practitioner's patient's ongoing management;

(i) Work with and as part of a multi-disciplinary health care team, including provision of effective communication – written and verbal, to ensure the best possible care for their patients;

(j) Provide adequate instruction to BH staff and other Accredited Practitioners to enable them to understand what care the Accredited Practitioner requires to be delivered to his or her patients and appropriately supervising the care that is provided by BH staff and other Accredited Practitioners;

(k) Visit patients with reasonable frequency having regard to each patient's clinical condition and needs;

(l) 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 admitting Accredited Practitioner;

(m) Comply with all infection prevention and control procedures of BH including appropriate hand hygiene;

(n) Take into account the policies of BH when exercising judgement regarding the length of stay of patients and the need for ongoing hospitalisation of patients.

6.4 Admission and Discharge of Patients

(a) To eliminate the instances of drug transcription errors and as part of BH's focus on delivering optimal patient care, it wishes where appropriate, to involve the family medical practitioner in compiling an accurate record of established medications prior to hospitalisation. Refer to By-law 6.5 Orders for Medication and/or Medical Care.

(b) The Pre-admission Service is available Monday to Friday via appointment with the Admissions Department. All Accredited Practitioners are encouraged to use this service for patients undergoing significant/major surgery.

(c) Patients for admission are admitted the day of surgery unless otherwise specified based on clinical need.

(d) For short stay procedure (day surgery) patients, the aim is for admission within one hour of their scheduled surgery time. Discharge will be within the designated length of stay for their condition unless the patient suffers a clinical complication which requires additional care. These patients are required to provide BH with information regarding their mode of transport home following the procedure. Where they are not able to provide this information admission may be deferred until such time as safe discharge and transport home can be arranged.

(e) Where it is known that the patient may be a source of danger and/or cause for undue concern to either staff or other patients, the admitting Accredited Practitioner must inform prior to the admission, either the CEO or the DCO who shall be responsible to assess and ensure BH is able to safely accept the patient. BH reserves the right to deny admission to any patient to whom it considers it will not be able to provide safe care. Furthermore, BH reserves the right to decline a request for admission for any patient.

(f) The BH Clinical Risk Program admission exclusion criteria taking account of BHs ability to provide safe care to patients, have been adopted (refer attachment 7, Admission Exclusion Criteria). Functional guidelines, outlining the capability of clinical units are provided in the BH orientation material for Accredited Practitioners and are available from BH. All Accredited Practitioners are expected to be familiar with these criteria and to be familiar with them as amended from time to time and to exercise judgement within these criteria when seeking admission of a patient to the hospital.

(g) It is expected that patients shall be discharged within the expected length of stay for their principal diagnosis unless the patient's clinical condition dictates otherwise in which event the patient's principal diagnosis would reflect a more complex condition.

(h) Discharge time is 10.00am. Patients unable to be discharged at this time may be required to wait in BH's discharge lounge.

6.5 Orders for Medication and/or Medical Care

(a) Compliance with statutory requirements together with the implementation of a specially designed drug chart has eliminated the need for nursing staff to transcribe drugs. It is the responsibility of the treating Accredited Practitioner to complete the BH Medication Chart to enable the patient's medication to be administered in a timely manner.

(b) All orders for medication must be recorded in writing using the BH Medication Chart, either at the time of prescription or within 24 hours of such an order being given. Any orders given over the telephone must be given to two members of the nursing/midwifery staff, one of whom must be a registered nurse/midwife. The second nurse/midwife must repeat the order back to the Accredited Practitioner to ensure the order has been correctly written. Such an order shall be signed by the Accredited Practitioner within 24 hours.

(c) For elective surgical patients, on admission each patient's established medications shall be transcribed to a BH medication chart by the patient's treating Accredited Practitioner at the practitioner's first visit to the patient.

(d) When a patient wishes to administer his/her own medication, the Accredited Practitioner must sign the BH Medication Chart for each medication stating that the patient is self administering his/her own medication.

(e) Orders for medical care must be recorded in writing in the patient's medical record and made known to relevant nursing/midwifery staff. (See also By-law 6.7).

6.6 Provisions in an Emergency

(a) Where an emergency arises in relation to any patient within the hospital, BH shall be authorised to take such action as it sees fit in the interest of the patient. This may include a request for attention by an available Accredited Practitioner.

(b) All reasonable attempts will be made to contact the treating Accredited Practitioner or the designated alternative practitioner.

(c) BH has established a Medical Emergency Triage System otherwise known as the Medical Emergency Team or MET which provides for emergency clinical care within defined limits to be administered by registered nurses/midwife credentialed by BH to do so.

(d) BH has a Patient and Family Activated Escalation of Care (REACH) rapid response program which empowers patients and families to escalate care if they are concerned about the condition of the patient by first encouraging engagement with the treating clinicians at the bedside. The REACH process aligns with the

Australian Commission for Safety and Quality in Health Care (ACSQHC) National Safety and Quality Health Service Standards (NSQHSS), Standard 9.9: Enabling patients, families and carers to initiate an escalation of care response. *(CEC 2011)*.

(e) Notwithstanding the categories of responsibilities granted to an Accredited Practitioner by the BOD, a practitioner would, in the event of a medical, surgical or obstetric emergency situation, be entitled to perform whatever acts or procedures he or she deemed necessary to preserve the health and life of a patient, in consultation with the DCO as required.

6.7 Medical Records

Accredited Practitioners must:

(a) Maintain full, accurate, legible and contemporaneous medical records for each patient under his or her care or ensure that such adequate clinical records are maintained in the patient's medical record such that, in an emergency, another suitably qualified Accredited Practitioner can expeditiously take over the care of the patient;

(b) Take all reasonable steps to ensure that adequate medical records are maintained for all patients under his or her care in accordance with the requirements of the National Safety and Quality Health Service Standards 2012 and including such other data reasonably required by BH to enable it to collect revenue in a timely manner and any other data reasonably required in respect of BH, including as a minimum:

(i) pre-admission notes or a letter on the patient's condition and plan of management, including notifying BH of significant co-morbidities;

(ii) full and informed written patient consent including anaesthetic consent;

(iii) recording an appropriate patient history, reason for admission, physical examination, diagnosis or provisional diagnosis and treatment plan before treatment is undertaken, unless involving an emergency situation;

(iv) therapeutic orders;

(v) particulars of all procedures including anaesthesia, all pathology and radiology reports;

(vi) observations of the patient’s progress;

(vii) notes of any special problems or complications;

(viii) discharge notes, completed discharge summary and documentation of the requirements and arrangements for follow-up;

(ix) each attendance upon the patient with the entries dated, timed, signed and specifying the designation of the practitioner.

(c) 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 Surgical Assistant, Anaesthetist, other Medical Practitioner and any Medical/Surgical company representative present. Operation reports shall be completed as soon as is practicable and the report signed by the Accredited Practitioner and made part of the patient’s medical record;

(d) Ensure anaesthetic procedures are detailed on the anaesthetic record;

(e) Ensure the provision of CMBS item numbers and adequate information to enable accurate coding for

reimbursement by health funds;

(f) Where orders are given by telephone they must be given to two members of the nursing/midwifery staff, one of whom must be a registered nurse/midwife. The second nurse/midwife must repeat the order back to the Accredited Practitioner to ensure the order has been correctly written. The Accredited Practitioner must sign the order within 24 hours;

(g) Ensure that the medical records maintained by the Accredited Practitioner are sufficient for the review of patient care;

(h) Take all reasonable steps to ensure that, following the discharge of each patient, the patient's medical record is completed within a reasonable time after the patient's discharge.

6.8 Patient Consent including Consent for Anaesthesia

All Accredited Practitioners who are to undertake a procedure or treatment at BH (including anaesthesia) must ensure that each patient, or the guardian of the patient in the case of a minor or for persons with an intellectual disability, who is to undergo a procedure or treatment has been fully informed of:

(a) The description of the planned procedure, stating site when applicable;

(b) The risks and benefits of the treatment and are understood by the patient/guardian;

(c) Additional treatment and procedures that may be necessary (and the possibility of unintended procedures or treatment);

(d) Details of the type of anaesthetic and written consent obtained;

(e) The transfusion of blood and / or blood products and blood being collected and tested for infectious agents.

The Consent must be signed and dated by both the patient/guardian and the Accredited Practitioner.

Where the Accredited Practitioner wishes to use a Consent Form, other than the BH Consent Form, approval for use must be sought from the Medical Executive Committee to ensure it complies with relevant legal requirements.

The Accredited Practitioner must ensure that the Consent Form is delivered to BH's Admissions Service, at or before the time of admission of the patient.

All patients undergoing an anaesthetic must have a pre-operative assessment which must be conducted by a Medical Practitioner with the appropriate Accredited Scope of Clinical Practice.

6.9 Conduct of Surgery

It is the Accredited Practitioner's responsibility:

(a) To ensure that an appropriate Accredited Surgical Assistant under By-law 7 is available for all surgery where an assistant is required;

(b) To be ready to operate at the time arranged;

(c) To ensure that relevant tissues removed at operation are labelled correctly and sent for pathological diagnosis and reports derived from such an examination must be signed as noted by the Accredited Practitioner and included in the patient's medical record.

As a component of its clinical risk reduction plan, BH has adopted specific measures concerning starting, the interruption of a list for a clinical emergency, and finishing times for surgical procedures.

Specific measures are in place to ensure safe work practices within the Perioperative Suite. These include scheduling of elective surgery, emergency surgery, the "team time out" process, and approval for the presence in the operating room of a family member or carer. BH Policy No POL-071 Safe Work Practices (Perioperative Suite and Labour Ward) (Attachment 3) and the Guidelines for Managing Obstetric Emergencies Organisational Decision Making in the Operating Suite (GUID-020) (Attachment 4) detail these requirements.

Should experimental or significant change in treatment or techniques be planned in or at BH such change shall only proceed in accord with BH Introduction of new Medical Technologies and Techniques Policy (POL-031) (Attachment 6) Refer to By-law 6.26.

6.10 Standing Orders

Standing orders for use in the clinical areas to assist nurses/midwives in the coordination and implementation of predictable assessment and treatment procedures are to be provided by Accredited Practitioners to ensure approved, authorised, documented direction regarding the patient's proposed care.

Standing orders must:

- Be reviewed and signed at least each three years by the Accredited Practitioner;
- Be consistent with the policies and procedures of BH;
- Include written instructions for pre and post-operative management of patients;
- Be consistent with the guidelines of the relevant professional college;
- Not contravene any Laws;
- Not include any regularly administered medication orders. (Medications are only to be administered from medication chart).

6.11 Clinical Activity

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

(a) The Accredited Practitioner is familiar with the operational policy, procedures and practices of BH;

(b) The Accredited Practitioner is able to contribute actively and meaningfully to BH relevant to his or her Scope of Clinical Practice and to appropriate hospital committees.

6.12 Participation in Committees

The CEO from time to time may request any Accredited Practitioner to nominate himself or herself to act as a member of a committee. Before doing so the CEO must have regard to:

(a) The Accredited Practitioner's current or recent historical contribution to committee or committees (relative to the Accredited Practitioner's peers);

(b) The Accredited Practitioners clinical activity at BH (relative to the Accredited Practitioner's peers);

(c) Any extenuating circumstances which the CEO considers may reasonably preclude the Accredited Practitioner from acting as a member of a particular committee (e.g. extraordinary voluntary commitments to the clinical advisory committees).

A member of any committee or subcommittee who has a direct or indirect pecuniary interest or a conflict of interest or a potential conflict of interest:

(a) In a matter that has been considered or is about to be considered at a meeting shall not participate in the relevant discussion or resolution of any such interest or matter nor shall such person be eligible to hold any office whilst such conflict of interest or potential conflict exists;

(b) Shall as soon as possible after relevant facts relating to a matter under discussion have come to the person's knowledge disclose the nature of the interest at the meeting.

6.13 Emergency / Disaster Planning

Accredited Practitioners must:

(a) Be aware of their role in relation to emergency and disaster planning;

(b) Be familiar with BH's safety and security policies and procedures;

(c) Participate in emergency drills and exercises which may be conducted at BH.

6.14 Professional Indemnity Insurance

Accredited Practitioners who are not otherwise fully indemnified by BH must maintain a level of Professional Indemnity Insurance:

(a) Which covers all potential liability of the Accredited Practitioner in respect of BH and patients;

(b) Appropriately reflects and covers the Accredited Practitioner's Scope of Clinical Practice and activities performed at BH;

(c) That is on terms and conditions acceptable to BH.

Accredited Practitioners must advise BH immediately if their Professional Indemnity Insurance is at any time cancelled, not renewed or revoked or qualified in any way whatsoever.

6.15 Annual Disclosure

Accredited Practitioners must furnish annually to BH or otherwise upon request by BH evidence of:

(a) Appropriate Professional Indemnity Insurance including the level of cover and any material changes to cover that occurred during the previous twelve months;

(b) Medical/dental registration (as applicable);

(c) Compliance with the mandatory continuing education requirements of his or her specialist college or body.

6.16 Continuous Disclosure

Each Accredited Practitioner must keep the CEO continuously informed of matters which have a material bearing upon his or her:

(a) Credentials;

(b) Scope of Clinical Practice;

(c) Ability to deliver health care services to patients safely and in accordance with his or her authorised Scope of Clinical Practice;

(d) Any adverse outcomes or complications in relation to the Accredited Practitioner's patient or patients (current or former) of BH;

(e) Professional Indemnity Insurance status;

(f) Registration with the relevant professional registration board, including any conditions or limitations placed on such registration.

6.17 Advice of Material Issues

Without limiting By-Law 6.16, Accredited Practitioners must advise the CEO in writing as soon as possible but at least within 14 days if any of the following matters occur and come to the attention of the Accredited Practitioner:

(a) An adverse finding made against him or her by any registration, disciplinary, investigative or professional body;

(b) His or her professional registration being revoked, suspended or amended (including the imposition of any Conditions);

(c) Any change in his or her Professional Indemnity Insurance, including but not limited to the attaching of Conditions, non-renewal or cancellation;

(d) His or her accreditation at, 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;

(e) He or she incurs an illness or disability which may adversely affect his or her current fitness;

(f) Any claim, or any circumstance which may give rise to a claim, in respect of the management of a patient of that Accredited Practitioner in BH (including all relevant details);

(g) He or she being charged with, or convicted of, any indictable offence or under any laws that regulate the provision of health care or health insurance.

6.18 Working with Children Checks/Criminal History Checks

(a) The Accreditation of Accredited Practitioners is conditional on the practitioner satisfactorily completing any checks that BH may require for the purpose of fulfilling BH's obligations under the *Children's Protection Act (SA) 1993.*

(b) The Accredited Practitioner must undertake to BH that he or she is not a Prohibited Person, and:

(i) has never, to the Accredited Practitioner's knowledge, been included on any list of persons not to be employed or engaged in a child related area of activity;

(ii) has not retired or resigned from, or had any previous employment, engagement, approval or accreditation terminated on the grounds that the Accredited Practitioner engaged in Child Protection Reportable Conduct;

(iii) has never been charged with or been the subject of an investigation as to whether he or she engaged in any Child Protection Reportable Conduct;

(iv) will not engage in any Child Protection Reportable Conduct.

6.19 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 Law (SA) Act 2010*.

6.20 Notice of Absence

Accredited Practitioners who have been treating patients at BH must use their best endeavours to notify the CEO in writing, at least 4 weeks in advance of any period during which they will not be treating patients at BH, so that the CEO may make appropriate, alternate arrangements during the Accredited Practitioner's absence.

6.21 Medical/Surgical Supplies, Clinical Equipment and Item Numbers

All Accredited Practitioners are expected to actively cooperate with BH in achieving efficient and cost effective use of medical and surgical supplies. Whilst BH is unable to guarantee that the preferences of all Accredited Practitioners will be accommodated, reasonable effort will be made to do so within BH's financial resources.

All applicants for Accreditation are required to provide with their application for Clinical Privileges a preference card which lists major consumable items re medical and surgical supplies including current unit cost estimates. The inclusion of item numbers routinely used will assist BH in reviewing this information.

Where access to particular specialist equipment is required such equipment shall be identified in the application for Clinical Privileges to assist BH in determining its ability to accommodate the applicant's needs.

6.22 Informed Financial Consent

In line with the requirement of our hospital preferred provider agreements (HPPAs) with health insurance companies, BH is required to ensure, preferably prior to admission, that patients have been formally advised of any out-of-pocket expenses they are likely to incur during their hospitalisation including those for hospitalisation and medical services. The process must be documented and include an acknowledgement to be signed by the patient that he/she has been given full information in respect of these issues. This then constitutes informed financial consent.

In respect of any out-of-pocket medical expenses the patient is likely to incur, it is the responsibility of the admitting Accredited Practitioner to fully inform their patient in this regard. The Accredited Practitioner is encouraged to avoid charging excessive fees which fall outside what is considered reasonable by peers of the relevant discipline.

6.23 Responsibilities under the Work Health & Safety Act (SA) 2012

Accredited Practitioners must ensure that they comply with (and must cooperate with BH to ensure compliance with) all duties and obligations under the *Work Health Safety Act, (SA) 2012*, including Part 2 – Health and safety duties, clause 16 – More than one person can have a duty and Part 2 – Primary duty of care, clause 19 – Primary Duty of Care and Part 2, Division 3 – Further duties of persons conducting businesses or undertakings, clauses 20, 21 Without limiting the above, Accredited Practitioners shall take all reasonable precautions to prevent and minimise risks to the health and safety of themselves and others who may be affected by their acts or omissions.

Without limiting the above Accredited Practitioners shall use supplied equipment, including personal protective wear, in the correct manner, report immediately to a person in authority, any hazards or injury sustained and ensure that they are not, by the consumption of alcohol or drugs or otherwise, in such a state as to endanger their own safety, or the safety of any other person in the hospital.

All Accredited Practitioners are required to familiarise themselves with BH's fire and emergency procedures at the time of commencing practice at BH and thereafter as requested by BH. See also By-law 6.13.

The above is not intended to be an exhaustive statement of duties under the Work Health Safety Act or the steps required to manage risk in compliance with these duties.

6.24 Hospital Preferred Provider Agreements (HPPAs) with Private Health Insurers

Each of the agreements which BH has signed to provide hospital care for the members of particular Private Health Insurance companies requires BH to provide such care in accord with the terms of each agreement. Such terms include the benefit to be paid as full payment for each patient, designated service standards, policy, funding and administrative guidelines governing the agreement. The management of length of stay in accord with best practice peers and the management of the cost of prosthesis are two further important considerations in fulfilling the conditions of these agreements. Accredited Practitioners are expected to co-operate with BH in meeting its obligations under the HPPA's as advised by either BH or the health funds.

6.25 Conduct of Clinical Trials and Research

The conduct of clinical trials shall only be approved in accord with BH requirements which include reimbursement to BH of all costs incurred in the conduct of such trials. Accredited Practitioners are required to formally advise BH annually of current and proposed research/clinical trials for notification to BH's indemnity insurer.

6.26 Clinical Approval for Introduction of New Medical Technologies and Techniques

An Accredited Practitioner shall not, without obtaining the approval of the CEO, who can seek advice from the CPRC and/or the MEC:

(a) Undertake any procedure or intervention which is different from accepted practice;

(b) Use any equipment which is new to a procedure or which is untried or experimental to that procedure.

An Accredited Practitioner wishing to introduce a new procedure / technique is to make an application in writing to the CPRC, where ethical clearance is required the applicant must produce evidence of approval from an ethics committee constituted in accordance with National Health and Medical Research Council guidelines.

An Accredited Practitioner must at all time act in accordance with the BH policy for the Introduction of new Medical Technologies and Techniques (POL-031). For the avoidance of doubt the BOD will determine whether any new equipment or procedure can be introduced or facilitated having regard to the BOD's assessment of BH's operational requirements and resources.

7. SURGICAL ASSISTANTS

7.1 Use of Surgical Assistants

(a) Accredited Practitioners must utilise as Surgical Assistants only those Surgical Assistants whose credentials have been verified and approved and who have been accredited by the CEO in accordance with these By-laws.

(b) Accredited Practitioners are responsible for the conduct of Surgical Assistants whilst performing procedures at BH.

7.2 Accreditation of Surgical Assistants

(a) The CEO may grant Accreditation to a Surgical Assistant after reviewing a completed *Application for Clinical Privileges* form and having satisfied themselves as to the credentials, judgement, current fitness and character of the Surgical Assistant.

(b) The CEO shall require the Surgical Assistant to nominate referees who can attest to those matters on which the CEO must be satisfied under By-law 7.2(a).

(c) All Surgical Assistants granted Accreditation under this By-law 7 will:

(i) Comply with the requirements and conditions for Accreditation as set out in these By-laws, to the fullest extent applicable to the Surgical Assistant;

(ii) Agree to the requirements and undertakings set out in By-law6.9.

(d) No Surgical Assistant granted Accreditation under this By-law 7 will be entitled to admit patients into the facility or make decisions regarding their clinical management.

(e) No Surgical assistant granted Accreditation under this By-law 7 will be entitled to amend their Scope of Clinical Practice.

(f) No right of review or appeal will exist in respect of the termination of the Accreditation of a Surgical Assistant.

8. PROCEDURES FOR CONSIDERATION OF AND GRANTING OF ACCREDITATION TO BURNSIDE HOSPITAL

The CPRC is responsible for reviewing documentary and other evidence provided by applicants for Accreditation to BH. Such documentation should demonstrate the following:

(a) Professional registration held and current entitlement to practise;

(b) Qualifications and training including undergraduate, postgraduate and special training with respect to the privileges requested;

(c) Recent clinical experience and competence in the Scope of Clinical Practice in which privileges are sought;

(d) That the applicant has subjected and will continue to subject the results of clinical work to quality assurance mechanisms including clinical audit and peer review processes;

(e) Commitment to past and continuing professional education;

(f) Satisfactory professional referee reports including peer comments which demonstrate that the applicant has and maintains the confidence of his peers;

(g) Acceptable and safe practice as evidenced by personal history of complaints, professional body investigations, indemnity and legal records.

Model criteria for all Accreditation categories and model criteria for delineation of Clinical Privileges have been adopted (attachment 1).

The CPRC makes recommendations to the BOD but it is the BOD that has an absolute discretion to grant, suspend or withhold Clinical Privileges for any period.

8.1 Applications

Applications for Clinical Privileges to BH shall be submitted on the *Application for Clinical Privileges* form. The form shall be signed by the applicant and shall include the required information as per the form. Applications cannot be proceeded with until all required information has been provided.

8.2 Period of Accreditation

The 31st October each three years has been adopted as the common appointment date and hence duration of all Accreditation is related to this date. At the expiration of the current period, all Accreditations are at an end and there is no automatic renewal thereof. A fresh application must be lodged in accordance with these By-laws.

Accreditation is ordinarily granted for a period of three years but the BOD can grant for any period at its discretion. The BOD on the recommendation of the CPRC or otherwise will fix the period of the granted privileges and without limitation this may include a probationary period of up to one year. The CPRC may recommend to the BOD that a probationary period be served by an individual with respect to Clinical Privileges. In such instances, the CPRC shall determine the purpose of the probationary period, training requirements and method of evaluation at the end of the probationary period. All new Accredited Practitioners may be required to serve a one year probationary period.

8.3 Temporary Accreditation (Locums and Short Terms Accreditations)

The granting of temporary privileges for short term Accreditations, such as locums, without recourse to the CPRC, is vested in the CEO or their delegate and where considered appropriate, in consultation with the Chair of the CPRC. Such Accreditations shall be subject to the applicant providing the information detailed on the Accredited Practitioner Short Term Accreditation form.

8.4 Processing of Applications

The application shall be forwarded to the CEO for processing following which it will be presented to the CPRC (Attachment 7, Terms of Reference).

For the purpose of considering each application the CPRC should consist of but not be limited to the following:

(a) Current members of the MEC;

(b) A nominee of the BOD who shall be an Accredited Medical Practitioner;

The CPRC has the option of inviting a member of the relevant professional college to attend its meetings if required.

The CPRC will consider all information submitted to it on behalf of BH, together with the peer recommendations and any other information concerning the applicant and the requirements of BH as it considers relevant. Refer to the Application for Clinical Privileges obtainable from the CEO's Executive Assistant.

This information may be gathered via self assessment tools validated by BH, clinical audits, peer reviews, annual performance reviews, procedural log books that include numbers and outcomes of procedures and from professional registration authorities.

The CPRC will report to the BOD with a recommendation as to whether or not the applicant should be granted Clinical Privileges specific to the Scope of Clinical Practice to be granted to the applicant and as to whether or not conditions should be attached to the granting of those privileges.

The BOD will consider the recommendations of the CPRC but the BOD may take into account any information it considers appropriate in its absolute discretion in making its decision. The decision of the BOD is at its absolute discretion and shall be notified to the applicant in writing..

The decision of the BOD is final and there is no right of review or appeal therefrom.

8.5 Re-Accreditation Procedure

BH will generally endeavour to notify Accredited Practitioners of the end of the Accreditation period but it is ultimately the Accredited Practitioner's responsibility to make application for a renewal of their Clinical Privileges. The Accredited Practitioner must exercise their own responsibility to ensure that their Accreditation status with BH remains current at all times.

An applicant for re-Accreditation must send the completed form to the CEO prior to the expiration of their Clinical Privileges in a timely manner to ensure effective continuity of Accreditation.

The re-Accreditation application will be presented to the CPRC which then makes a recommendation to the BOD and the BOD will decide in its absolute discretion in the same way as applies to an original application.

Without limiting the above in addition to the required demographic information (see application form) an individual's professional performance, peer recommendations and other indicators of current competence may be taken into account. Such indicators would include participation in quality activities, clinical risk reduction, undertaking continuing professional development, maintenance of proper and timely medical records and maintaining effective working relations with BH staff. Evidence of these activities is to accompany an application for re-Accreditation.

Upon receipt of the completed form, it shall be considered by the CPRC for subsequent action, and in respect of which By-law 8.4 will apply.

In order to accommodate exceptional circumstances, the CEO shall have the power to extend an Accreditation period for a temporary period.

8.6 Accepting Clinical Responsibility

Every practitioner accredited at BH shall only undertake practices within the Scope of Clinical Practice granted by the BOD. Accredited Practitioners practising outside the designated Scope of Clinical Practice could result in a review of Clinical Privileges including suspension or revocation in accordance with the processes set out in these By-Laws.

8.7 Review of Clinical Privileges

In the following circumstances a review of Clinical Privileges will be undertaken by the CPRC which shall make recommendations to the BOD in respect of its findings:

(a) At the end of any specified period;

(b) At the time of each renewal application, i.e. temporary, one or three years as is relevant to theapplicant;

(c) At the request of the DCO, CEO, Chair of the MEC or CPRC or the individual practitioner to whom the privileges apply. If as a result of such a request, the BOD determines that the Accredited Practitioner's Clinical Privileges should be revoked, suspended or the scope of them reduced the Accredited Practitioner may invoke the review process set out in By-law 10 below.

9 DELINEATION OF CLINICAL RESPONSIBILITIES

Each application for Accreditation or re-Accreditation to BH must contain a request for Clinical Privileges detailing the Scope of Clinical Practice desired by the applicant. Requests for Clinical Privileges shall be evaluated on the basis of the requirements set out in these By-laws.

An Accredited Practitioner who has been treating patients at BH is responsible for facilitating a locum tenens to cover any period of absence. The practitioner shall ensure that the locum doctor is competent and is informed as to the usual patterns of practice at BH. It is a requirement that a locum doctor has been granted Clinical Privileges by BH and has been approved in advance by BH to undertake the proposed locum work. (Refer By-law 8.3) Completion of Short Term Accreditation form is required.

10. CORRECTIVE ACTION

10.1 CEO to deal with matters

(a) Whenever a matter arises whether by way of a complaint, report or otherwise in relation to the performance, conduct, activity or circumstances of an Accredited Practitioner which the CEO considers may warrant remedial action the CEO may deal with the matter as they consider appropriate in the circumstances unless the CEO decides that the matter warrants consideration of the continuation, scope, duration or status of the Accredited Practitioner's Clinical Privileges in which case the CEO may elect to invoke the processes set out in By-laws 10.2 and/or 10.7 below.

(b) Without limitation a complaint or report in relation to the performance, conduct, activity or circumstances of an Accredited Practitioner may be received by the CEO from an Accredited Practitioner, a chair or member of a clinical advisory committee, a member of the BOD, a staff member, patient or family member of a patient.

10.2 Matters to be referred to a Clinical Privileges Review

(a) If the CEO considers that a matter in relation to an Accredited Practitioner warrants consideration of the continuation, scope, duration or status of the Accredited Practitioner's Clinical Privileges the CEO may instigate the following review process (Clinical Privileges Review).

(b) Without limitation examples of circumstances in which the CEO may consider that the matter ought to be referred for a Clinical Privileges Review are where the CEO considers that the matter raises issues with regard to:

(i) actual or potential risk of detriment to patient care, safety or outcomes;

(ii) concerns with clinical competence;

(iii) possible Unprofessional Conduct, Unsatisfactory Professional Performance or Professional Misconduct;

(iv) potential Impairment;

(v) the Accredited Practitioner being convicted or charged with a criminal offence or being under investigation by a law enforcement agency or regulatory authority;

(vi) the Accredited Practitioner's registration becoming subject to a condition or restriction;

(vii) risks to the wellbeing, health or safety of BH staff, visiting practitioners, contractors or visitors;

(viii) disruption to the efficient operations or interests or reputation of BH;

(ix) a material or repeated breach of the Code of Conduct (including breach of BH policies or procedures).

10.3 Peer Group referral and recommendations

(a) The CEO will facilitate a group of two or three of the Accredited Practitioner's peers (at least one of whom is a member of the CPRC) (Peer Group) and will refer the matter to the Peer Group.

(b) As soon as reasonably practicable the Peer Group will discuss the matter with the Accredited Practitioner and report to the CEO on:

(i) their assessment of the matter;

(ii) the Accredited Practitioner's response to the matter;

(iii) their recommendations on what, if any, remedial action should be taken.

(c) Further action that the Peer Group may recommend may include but is not limited to:

(i) counselling, warning or reprimand;

(ii) ongoing monitoring, review and reporting;

(iii) suspension, revocation or amendment to the Accredited Practitioner's Clinical Privileges.

10.4 BOD decision on remedial action

(a) The CEO will place before the BOD the recommendations of the Peer Group.

(b) The BOD will consider the Peer Group's recommendations and determine in its discretion what, if any, remedial action shall be taken (including but not limited to any of the remedial action set out in By-law 10.3(c) above). The BOD will determine when any remedial action is to take effect, which may be immediately.

(c) The Accredited Practitioner will be notified in writing of the decision of the BOD and any remedial action as soon as reasonably practicable.

10.5 CPRC Review

(a) If within 14 days of being notified of the BOD decision the Accredited Practitioner notifies the CEO in writing that the practitioner is aggrieved with the decision, the matter will be referred to the CPRC to review the decision (CPRC Review). Such referral shall not operate as a stay of the BOD's decision or any remedial action taken.

(b) The CPRC shall undertake a review of the BOD's decision.

(c) The CEO or their nominee shall place before the CPRC all the information considered relevant to the matter and will provide that information to the Accredited Practitioner in so far as it has not already been provided.

(d) The Accredited Practitioner will be invited to submit to the CPRC any information or matters that the practitioner wishes the CPRC to take into account.

(e) The CPRC will determine in its discretion, after consulting with the CEO, the procedure for the review including whether to receive the Accredited Practitioner's submission in writing or in person.

(f) The CPRC will use its best endeavours to complete its review as soon as practicable.

(g) Following conclusion of the CPRC Review the CPRC will provide its written recommendations to the BOD including in relation to remedial action (including but not limited to any of the remedial action set out in By-law 10.3(c) above).

10.6 BOD decision following CPRC Review

(a) The BOD will consider the CPRC Review recommendations. If it is the preliminary view of the BOD not to substantially accept the recommendations of the CPRC, then the members of the CPRC and the BOD shall meet jointly to discuss the matter.

(b) The BOD will make a final decision in its absolute discretion including in relation to remedial action (including but not limited to any of the remedial action set out in By-law 10.3(c) above) and inform the CEO.

(c) The CEO will notify the Accredited Practitioner of the BOD's decision.

(d) The decision of the BOD shall be final and there will be no further right of review or appeal therefrom.

10.7 Summary Suspension

(a) Notwithstanding anything else in these By-laws, following consultation with the Chair of the BOD and with either the Chair of the CPRC or the Chair of the MEC, the CEO may immediately suspend all or part of the Accredited Practitioner's Clinical Privileges if the CEO considers it is necessary or desirable (including without limitation due to any of the matters set out in By-law 10.2(b) above) to do so:

(i) in the best interest of patient care in BH;

(ii) to protect the well being, health or safety of BH staff, visiting practitioners, contractors or visitors;

(iii) to protect the interests or reputation of BH.

(b) Immediately upon suspension, the Chair of the CPRC or the Chair of the MEC shall have the authority to arrange alternative medical cover for any patients of the suspended Accredited Practitioner still in BH at the time of the suspension.

(c) If within 14 days of being notified of the BOD decision the Accredited Practitioner notifies the CEO in writing that the practitioner is aggrieved with the decision, or if the CEO otherwise requests, the matter will be referred to the CPRC to review the decision (CPRC Suspension Review). Such referral shall not operate as a stay of suspension.

(d) The CPRC shall consider whether the:

(i) the suspension should be continued, varied or lifted in whole or in part;

(ii) whether any other remedial action (including but not limited to any of the remedial action set out in By-law

10.3(c) above) is appropriate.

(e) The CEO or their nominee shall place before the CPRC all the information considered relevant to the matter and will provide that information to the Accredited Practitioner in so far as it has not already been provided.

(f) The Accredited Practitioner will be invited to submit to the CPRC any information or matters that the practitioner wishes the CPRC to take into account.

(g) The CPRC will determine in its discretion, after consulting with the CEO, the procedure for the review including whether to receive the Accredited Practitioner's submission in writing or in person.

(h) The CPRC will use its best endeavours to complete its review as soon as practicable.

(i) Following conclusion of the CPRC Suspension Review the CPRC will provide its written recommendations to the BOD including in relation to the matters in By-law 10.7 above.

10.8 BOD decision following CPRC Suspension Review

(a) The BOD will consider the CPRC Suspension Review recommendations. If it is the preliminary view of the BOD not to substantially accept the recommendations of the CPRC, then the members of the CPRC and the BOD shall meet jointly to discuss the matter.

(b) The BOD will make a final decision in its absolute discretion including in relation to the matters in By-law 10.7(d) above and inform the CEO.

(c) The CEO will notify the Accredited Practitioner of the BOD's decision.

(d) The decision of the BOD shall be final and there will be no further right of review or appeal therefrom.

10.9 Automatic Suspension

(a) The Clinical Privileges of an Accredited Practitioner shall be automatically suspended without the need for any further action on the part of the BOD in the event that an Accredited Practitioner's board registration has been revoked, suspended or not renewed.

(b) The CEO will notify the BOD and the Accredited Practitioner of the suspension as soon as reasonably practicable.

(c) If the revocation, suspension or non-renewal of registration is lifted or rectified the CEO may at their own initiative or at the request of the Accredited Practitioner ask the BOD to review the suspension.

(d) If the BOD decides not to lift the suspension the Accredited Practitioner may refer the matter for a CPRC Suspension Review in accordance with By-law 10.7 above.

11. REVIEW OF THESE BY-LAWS

These By-laws shall be reviewed and revised regularly. Changes to these By-laws shall be approved by the BOD prior to implementation. Changes to the By-laws shall come into force at the date on which the BOD's approval is assigned to the document by way of the signature of the Chair of the BOD.

Anne Hinton
Chair, Board of Directors

Alison Fitzgerald
Chair of the Quality/Governance Committee

Dr Andrew Lord
Medical Officer Representative

Alan Morrison
Chief Executive Officer

Approved by: Burnside War Memorial Hospital's Board of Directors, 25/05/2022. Administrative review 21/09/2023.

ASSOCIATED BURNSIDE HOSPITAL DOCUMENTS:

Attachment 1:
GUID-169 *Guidelines for Accreditation Categories for Accreditation (to Burnside Hospital)*

Attachment 2:
ATTAC-022 *Burnside Hospital Code of Conduct*

Attachment 3:
POL-071 *Safe Work Practices (Perioperative Suite and Labour Ward)*

Attachment 4:
GUID-020 *Guidelines for Managing Obstetric Emergencies Organisational Decision Making in the Operating Suite*

Attachment 5:
POL-031 *Introduction of New Medical Technologies and Techniques*

Attachment 6:
POL-154 *Burnside Hospital Admission Exclusion Criteria*

Attachment 7:
TOR-013 *Clinical Privileges Review Committee (CPRC) Terms of Reference*

REFERENCES:

- Australian Commission for Quality & Safety in Health Care - Credentialing health practitioners and defining their scope of clinical practice: A guide for managers and practitioners (2015)
- Australian Commission for Quality & Safety in Health Care - Standard for Credentialing and Defining the Scope of Clinical Practice (2004)
- Australian Commission on Safety and Quality in Health Care - Clinical Governance Standard

RELEVANT LEGISLATION AND AUSTRALIAN STANDARDS FOR INFORMATION:

- AS/NZS ISO 31000:2009 Risk Management – Principles and Guidelines
- AS4187:2014: Reprocessing of reusable medical devices in health service organisations
- Consent to Medical Treatment and Palliative Care Act (SA) 1995
- Controlled Substances Act (SA) 1984
- Health Care Act (SA) 2008
- Health Practitioner Regulation National Law (SA) 2010
- Mental Health Act (SA) 2009
- Work Health and Safety Act (SA) 2012

Please note that this list is not exhaustive and may be changed or added to

GUIDELINES FOR ACCREDITATION CATEGORIES FOR APPOINTMENT TO THE BURNSIDE HOSPITAL

Category	Details
Specialist Practitioner	* Specialist with an Australian Fellowship or equivalent; recognised by the Australian Health Practitioner Regulation Agency as a specialist. * May admit and treat patients within the terms of their Clinical Privileges granted by the BH CPRC * Responsible for the clinical care of their inpatients * Participates in continuing education activities of BH * Participates in the BH clinical risk and quality improvement activities * Is a member of the VMSA and entitled to represent the VMSA on BH clinical committees
General Practitioner	* FRACGP or equivalent, recognised by the Australian Health Practitioner Regulation Agency as a General Practitioner * May admit and treat patients within the terms of their Clinical Privileges granted by the BH CPRC * Responsible for the clinical care of their inpatients * Participates in continuing education activities of BH * Participates in the BH clinical risk and quality improvement activities * Is a member of the VMSA and entitled to represent the VMSA on BH clinical committees
Dentist	* Dentist currently registered with the Dental Board of South Australia * May admit and treat patients within the terms of their Clinical Privileges granted by the BH CPRC * Responsible for the clinical care of their inpatients * Participates in continuing education activities of BH * Participates in the BH clinical risk and quality improvement activities * Is a member of the VMSA and entitled to represent the VMSA on BH clinical committees
Consultant Emeritus	* Medical practitioner or Dentist who has provided distinguished service to BH and who has retired from active practice or is otherwise a member of the medical or dental profession of outstanding merit or extraordinary accomplishment and is awarded this title by BH * May be a member of the VMSA but is not entitled to represent the VMSA on BH clinical committees.
Consultant Specialist/ Consultant General Practitioner	<u>Consultant Specialist</u> * Specialist with an Australian Fellowship or equivalent; recognised by the Australian Health Practitioner Regulation Agency as a specialist. <u>Consultant General Practitioner</u>

	* FRACGP or equivalent > advises on treatment of patients in a consultant role with the admitting VMO * Participates in continuing education activities of BH * May be a member of the VMSA but is not entitled to represent the VMSA on BH clinical committees.
Surgical Assistant	* Specialist or General Practitioner with an Australian Fellowship or equivalent, recognised as such by the Australian Health Practitioner Regulation Agency as a specialist or general practitioner. * Provides surgical assistance to an accredited surgeon undertaking major surgical procedures. * No admitting rights *

Guidelines for the Delineation of Clinical Privileges

These Guidelines are for guidance in relation to categories that need to be taken into account regarding credentials and clinical privileges. There may be occasions where practitioners are not covered in the categories listed below. In such instances the CPRC shall determine the criteria to be met for privileges to be granted.

IMPORTANT NOTICE: All accredited practitioners with Clinical Privileges must be able to demonstrate participation in programs to maintain and improve the quality of care they give to patients so as to guarantee the highest possible clinical standards of care to the patients admitted to Burnside Hospital, including but not limited to participation in recognised quality assurance and clinical risk reduction activities, recognised continuing medical education and professional development activities. Accredited Practitioners must also be able to confirm that they undertake regular work of an appropriate volume and complexity as is necessary to maintain proper clinical standards of practice in the fields in which they have clinical privileges at Burnside Hospital. The requirements of the various medical colleges will be taken to mean the appropriate volume. In the event the appropriate volume is not specified by the relevant medical college the Medical Executive Committee shall determine the level which is to apply.

ANAESTHESIA	
General	* FANZCA or equivalent
Paediatric	* FANZCA or equivalent * Demonstrate current experience in Paediatric Anaesthesia
DENTAL	
General	* BDSc or equivalent
Oral and Maxillofacial	* FRACD (OMS) or equivalent
DERMATOLOGY	
General	* FACD or equivalent
ENT SURGERY	
ENT Surgery – Adult	* FRACS (Otolaryngology, head and neck) or equivalent
ENT Surgery – Paediatric	* FRACS (Otolaryngology, head and neck) or equivalent * Completion of a recognised formal training program in Paediatric ENT Surgery
Paediatric Endoscopic ENT Surgery	* FRACS or equivalent * Completion of a recognised formal training program in Paediatric Endoscopic Otolaryngology
Head and Neck	* FRACS (Otolaryngology) or equivalent * Member of the A & NZ Head & Neck Society or equivalent
GASTROENTEROLOGY	

Gastroenterology	* FRACP or equivalent
Endoscopy and Colonoscopy	* Recognition by the Conjoint Committee for recognition of Endoscopy Training (College recognition of surgeons, College of Physicians and Gastroenterological Society of Australia) or equivalent.
ERCP (Endoscopic Retrograde Cholangio Pancreatography	* FRACS or FRACP or equivalent * Those practitioners wishing to have admitting rights in ERCP should have worked in ERCP in a major hospital during the last two years & be supported by two referees who can attest to this recent activity.
GENERAL SURGERY	
General Surgery	* FRACS
Endoscopy and Colonoscopy	* FRACS * Recognition by the Conjoint Committee for recognition of Endoscopy Training (College of Surgeons, College of Physicians and Gastroenterological Society of Australia) or equivalent
Advanced Laparoscopic Surgery	* FRACS * Provide evidence of advanced training in Laparoscopic Surgery in relevant areas
Paediatric	* FRACS (Paediatric Surgery) or equivalent
INTENSIVE CARE	
	* FJFICM or FRACP or equivalent
NEONATOLOGY	
	* FRACP (Neonatology) or equivalent plus completion of a recognised formal neonatal training program
OBSTETRICS & GYNAECOLOGY	
Obstetrics	* FRANZCOG or equivalent
Gynaecology – General	* FRANZCOG or equivalent
Gynaecology Oncology	* FRANZCOG/CIGO – Certificate in gynaecological oncology or equivalent
Advanced Endoscopic Surgery	* FRANZCOG or equivalent * Provide evidence of completion of recognised formal training in advanced endoscopic surgery i.e. recognised by AGES (Australian Gynaecological Endoscopy Society)
Urogynaecology	* FRANZCOG or equivalent * CU - Certification in Urogynaecology
ONCOLOGY	
Medical Oncology	* FRACP or equivalent
Radiation Oncology	* FRACP or equivalent * FRANZCR
OPHTHALAMOLOGY	
Adult	* FRACO or equivalent
Paediatric	* FRACO or equivalent
ORAL/MAXILLARY SURGERY	
Facio Maxillary Surgery	* FRACDS (OMS), FRACS (Plastic Surgery) or equivalent
ORTHOPAEDICS	
Orthopaedic Surgery - Adult	* FRACS (Orthopaedic Surgery) or equivalent

Orthopaedic Surgery - Paediatric	* FRACS (Orthopaedic Surgery) or equivalent * Completion of a recognised formal training program in paediatric orthopaedics
PAEDIATRIC MEDICINE	
General	* FRACP (Division of Paediatrics) or equivalent
Anaesthetics	* FANZCA or equivalent * Demonstrate current experience in paediatric anaesthesia
PAEDIATRIC SURGERY	
Paediatric Surgery	* FRACS (Paediatric Surgery) or equivalent
Anaesthetics	* FRAZCA or equivalent * Demonstrate current experience in paediatric anaesthesia
PALLIATIVE CARE	
	* FRACP or FANZCA or FRACR or equivalent
PATHOLOGY	
General	* FRCPA or equivalent
Infection Control	* FRACP and/or FRCPA or equivalent
PHYSICIANS / INTERNAL MEDICINE	
General Medicine	* FRACP or equivalent
Endocrinology	* FRACP or equivalent
Geriatrics	* FRACP or equivalent
Neurology	* FRACP or equivalent
Renal Medicine	* FRACP or equivalent
Respiratory Physicians	* FRACP or equivalent
Rheumatology	* FRACP or equivalent
PLASTIC AND RECONSTRUCTIVE SURGERY	
Hand Surgery	* FRACS (Plastic Surgery, orthopaedic or general) or equivalent
Facio Maxillary Surgery	* FRACD (OMS) or FRACS (Plastic Surgery) or FRACS or equivalent
Plastic, Reconstructive & Aesthetic Surgery	* FRACS (Plastic Surgery) or equivalent
Head and Neck	* FRACS (Plastic Surgery, ENT or General) or equivalent
RADIOLOGY	
	* FRANZCR * Those wishing to have interventional rights should have relevant training in the past two years and be supported by two referees who attest this recent activity.
REHABILITATION MEDICINE	
General	* FAFRM (RACP) or equivalent and demonstrated expertise in the relevant modality
UROLOGY	
Adult	* FRACS (Urology) or equivalent
Paediatric	* FRACS (Urology) or equivalent plus demonstrate current experience in paediatric urology.

VASCULAR SURGERY	
Vascular Surgery	* FRACS or equivalent with completion of a speciality training in Vascular Surgery * Those wishing to have interventional rights should be supported by two referees who can attest to this recent activity.

CODE OF CONDUCT

First issued:	February 2016	Next Review Due:	February 2025
Cross Reference:	Hospital Policy Manual	Standards:	Governance (1)

OBJECTIVE

All employees, volunteers, visiting practitioners and contractors (personnel) are required to promote by word, action and manner a positive influence upon the standard of care and service provided by Burnside Hospital (**BH**). We seek to create an atmosphere which harmonises with the promotion of quality care for patients with a values-driven working environment for our personnel. Good communication and conduct between all members of our health care team is essential.

This Code of Conduct provides a framework of appropriate behaviour by ensuring all persons engaging in work within, or for, BH:

- Always conduct themselves with the highest level of integrity, fairness, respect, and professionalism when interacting with patients and each other;
- Fulfil the vision, mission, values, goals and objectives of BH; and
- Perform their duties and obligations to the standards expected.

SCOPE

This Code of Conduct applies to all employees, volunteers, visiting practitioners and contractors (personnel) of BH. It is essential that all persons engaging in work at or for BH understand and respect not only their own rights and responsibilities but also the rights and responsibilities of other members of the hospital and community.

BH also recognises that professional employees may also be bound by professional codes of practice, conduct or ethics prescribed by their college, boards or association. BH recognises that that these codes may not always be in harmony with this Code of Conduct. It is an obligation of an employee or visiting practitioner to consider these codes in each circumstance and notify an appropriate director where any such conflict may arise.

OUR VALUES

All personnel are expected to embrace and display our values in the way they work. We value:

- Observing the rights of our patients, focussing on respect for their privacy, dignity and individual needs;
- The professional relationship with our visiting practitioners;
- Providing high quality care and services;
- Delivering service excellence through a collegial approach;
- Managing available resources effectively and efficiently;
- The continuing education and development of individuals;
- The right to enjoy a safe and healthy workplace.

OUR PERSONAL AND PROFESSIONAL CONDUCT

All personnel of BH are expected to take all reasonable action necessary to maintain and enhance the reputation of BH at all times.

BH supports principles of inclusion, diversity, equal opportunity and anti-discrimination. We expect all personnel to treat one another with respect, dignity, be accepting of individual differences and in completing their work, to duly abide by and uphold the principles of fair treatment, equal opportunity and non-discrimination.

Personnel are not to engage in activity or language which has the intent or effect of offending or embarrassing others or is in breach of legislative requirements.

When carrying out their duties, all personnel will:

- Conduct themselves with the highest level of integrity, fairness and professionalism;
- Carry out work efficiently, economically and effectively and to a professional standard which reflects favourably on themselves and BH;
- Commit to regular ongoing professional development to keep abreast of developments, particularly in the areas for which the individual has special responsibility;
- Follow any lawful and reasonable policy or directive from a person with the authority to give the direction;
- Comply with all relevant industry legislation, and adhere to applicable professional codes of practice, conduct or ethics and applicable policies and procedures of BH;
- Report personnel who behave dishonestly or in breach of this Code of Conduct;
- Present to work, or represent BH, in a professional manner that will in no way harm the image of BH or infringe any other policy or procedure of BH;
- Maintain individuals' rights to privacy, with regard for the needs of others and ensure all personal and private information is kept in confidence and in sharing information ensuring the confidentiality of information is communicated; and
- Not use, possess or distribute offensive materials in either printed, electronic or social media.

Managers are responsible and accountable for:

- The effective implementation, promotion and support of this Code of Conduct in their areas of responsibility;
- Ensuring personnel understand and follow the provisions outlined in this Code of Conduct;
- Reporting any breach or non-compliance with this Code of Conduct by themselves or others; and
- Acting consistently and fairly in dealing with behaviour that breaches this Code of Conduct.

CONFLICTS OF INTEREST

A conflict of interest arises where a person engages in activities which advance their personal interests at the expense of BH's interests or the interests of other personnel. A situation giving rise to an actual, potential or perceived conflict of interest can create difficulties in maintaining the integrity of BH's professional standards, such as but not limited to:

- Personal and family relationships which go beyond the level of a professional working relationship;
- Board membership, directorship or management of external organisations;
- Financial interests and affiliations;
- Receipt of gifts or benefits that could be viewed as an incentive or reward which might place compromise or place a staff member under an obligation to another person or external organisation;

- Acceptance of outside professional work or secondary employment, business, commercial or other activities outside of the workplace which has the potential to impact on BH; and
- Access to, and use of, information used for personal gain.

Where an employee wishes to engage in paid employment/business activities outside their employment with BH they are required to seek the approval of their manager. Where there is any real or potential conflict of interest their employment with BH is to come first.

It is the responsibility of all personnel to disclose details of situations that may give rise to an actual, potential or perceived conflict of interest. All personnel are required to take responsibility for their own conduct and are expected to take all appropriate measures to avoid situations that may give rise to conflicts between their private interests and their responsibilities and the interests of BH.

CORRUPT CONDUCT

Corrupt conduct commonly involves the dishonest or partial use of power or position which results in one person/group being advantaged over another. Corruption can take many forms including, but not limited to:

- Bribery and blackmail;
- Unauthorised use of confidential, intellectual or private information;
- Fraud; and
- Theft.

Any form of corrupt conduct will not be tolerated. Disciplinary action, including possibly dismissal, will be taken in the event of any employee participating in corrupt conduct.

Employees should note that breaches of certain sections of this Code of Conduct maybe subject to litigation under laws and legislation. Nothing in this Code of Conduct should prevent the reporting of criminal behaviour in accordance with the law to the appropriate statutory authority where there are sound grounds to do so.

BREACHES OF THE CODE OF CONDUCT

BH takes all reports of potential breaches of this Code of Conduct seriously. All personnel are encouraged to speak up where they observe or suspect something they believe may not be in BH's interest or in breach of this Code of Conduct. All personnel will be afforded support in raising concerns and may do so without fear of recrimination.

In the first instance, suspected non-compliance with this Code of Conduct should be reported to the CEO.

Breaches of this Code of Conduct by employees of BH may be subject to disciplinary action which may include (but is not limited to) counselling, informal/formal warnings and termination of employment. Any employees who are being investigated for a potential breach of this Code of Conduct will have an opportunity to be heard prior to any final determination in accordance with the investigation and disciplinary procedures outlined in BH's Disciplinary & Termination of Employment Policy POL-046.

Breaches of this Code of Conduct by Accredited visiting practitioners will be dealt with under the BH Accredited Practitioner By-laws (**By-laws**).

ACKNOWLEDGEMENT

All new personnel must sign an acknowledgement form confirming that they have received, read and understood the Code of Conduct and agree to abide by its provisions. Contractors are provided with a copy of this Code as part of their online induction & completion of the induction provides acknowledgement that they have read and understood expectations of BH.

Failure to read the Code of Conduct or sign the acknowledgement does not excuse a person from

compliance with the Code of Conduct.

I,_____, have been provided with, read and understood this Code of Conduct.

I acknowledge and agree to abide by this Code of Conduct.

Name:_____ Signature: _____ Date: _____

ASSOCIATED BURNSIDE HOSPITAL DOCUMENTS

Effective Working Relationships POL-039
Prevention of Harassment and Bullying POL-043
Secondary Employment Policy POL-085
Gifts and Benefits Policy POL-178
Confidentiality, Privacy, Conflict of Interest & Intellectual Property Policy POL-118
Grievance Resolution Policy POL-158
Disciplinary & Termination of Employment Policy POL-046
Accredited Practitioner By-Laws RES-054

REFERENCES

Medical Board of Australia - Good medical practice: a code of conduct for doctors in Australia
Nursing and Midwifery Board of Australia - Fact sheet: Code of conduct for nurses and Code of conduct for midwives

SAFE WORK PRACTICES
(PERIOPERATIVE SUITE & LABOUR WARD)

First Issued:	August 2003	**Next Review Due:**	September 2024
Cross Reference:	Perioperative Suite Manual Maternity Services Manual	**Standard(s):**	Governance (1)

POLICY

In the interest of safe work practice and in recognition of its responsibility to ensure safe patient care and a safe working environment for all concerned, Burnside Hospital has adopted specific requirements in relation to clinically urgent surgery, conduct of elective surgery, attendance in the operating room of a support person (family member or significant other) during the conduct of a procedure(s) and the use of video cameras.

RATIONALE

Consistent with best practice in clinical governance and risk management and the hospital's responsibilities under the Work Health & Safety Act (SA) 2012 in relation to safe work practice, all surgical procedures should be undertaken in optimum conditions for patients, staff and visiting clinicians.

1. CLINICALLY URGENT SURGERY

In this context the term "emergency" is taken to mean "clinically urgent surgery" and is defined as: *a sudden unforeseen clinical care crisis (usually involving significant danger to the patient) that requires immediate surgical intervention to reduce the risk to the patient's safety*. Conditions which fall within this definition include (but are not limited to) post operative haemorrhage, acute bowel obstruction, acute appendicitis, retained placenta, post partum haemorrhage and emergency caesarean section.

1.1 Interventions/Actions

- Clinical Manager Perioperative Service or the Hospital Coordinator / After Hours Hospital Coordinator will liaise with the responsible clinicians (surgeon & anaesthetist) in determining if the patient's condition falls within the above definition. Out of hours, if there is any difference of opinion with respect to the definition and the proposed course of action, the After Hours Hospital Coordinator is to be contacted by the Theatre Coordinator for advise regardless of the time, and if required, the Director Clinical Operations/Clinical Manager Perioperative Service.
- Clinical Manager Perioperative Service or the After Hours Hospital Coordinator is responsible for deciding that an emergency operation will proceed having regard for the availability of required hospital staff and facilities.
- The After Hours Hospital Coordinator in liaison with the Theatre Coordinator is responsible to make the necessary arrangements for the operation to proceed following the requisite approval.
- Clinical Manager Perioperative Service/Hospital Coordinator in collaboration with visiting clinicians is responsible to ensure sound operating list management.

1.2 Monitoring

All episodes of clinically urgent surgery shall be reviewed by the Perioperative Committee to ensure all episodes fall within the definition defined above.

2. ELECTIVE SURGERY OPERATING TIMES

Notwithstanding emergency situations elective surgery is to be undertaken within the designated hours listed below.

2.1 Interventions/Actions

- No elective surgical case should commence after 2100 hours. The Theatre Coordinator is to liaise with the After Hours Hospital Coordinator at approximately 1900 to update the progress of all remaining theatre lists, and to monitor/plan for any intervention accordingly. Discussion must include the predicted length of scheduled procedures.
- Where it is necessary to postpone elective surgery due to these time restrictions, every effort is to be made by Burnside Hospital to accommodate the case or cases concerned the following day or at a mutually acceptable time to the hospital and the surgeon concerned.
- The above arrangements do not apply to acute cases requiring either immediate surgery or surgery within a few hours.
- In the event that the surgeon and anaesthetist determine to proceed with surgical intervention they will be informed by the After Hours Hospital Coordinator that to do so is in contravention of this policy and that a RiskMan incident report will be instigated and reported to the Director Clinical Operations/Chief Executive Officer at the first available opportunity. The Director Clinical Operations/Chief Executive Officer will inform the Chairman of the Perioperative Committee who shall be responsible to investigate and instigate any required action to ensure safe working practices are maintained at all times reporting the outcome back to the Chief Executive.

2.2 Safe Staffing

The Hospital is committed to the operation of safe work practices and maintaining a work environment that is safe and without risks to the health and wellbeing of our staff, visiting medical officers and patients. This responsibility extends to ensuring we operate with safe staffing levels and skill mix and is achieved through the implementation of the following in relation to orthopaedic casemix:

- The maximum number of arthroplasty operations on any list is eight (8) with the option to add two (2) day surgery cases to a total of 10 day surgeries in any list
- Complex elective surgery (such as a planned revision) should ideally be performed early in an operating list but in any event should not start later than 7:00 pm
- There must be adequate turnaround time between cases to ensure perioperative staff have sufficient time to clean and prepare the theatre and equipment, and prepare themselves for the next case where they are to then be involved with the surgical safety checklist process

2.3 Monitoring

Breaches of the above requirements shall be reviewed by the Perioperative Committee with remedial action taken as required. A summary report shall be provided to the Medical Executive Committee meeting.

3. ATTENDANCE IN OPERATING THEATRE OF A NOMINATED SUPPORT PERSON

The attendance of a support person (family member or significant other) in the operating room during a procedure is at the discretion of the Clinical Manager Perioperative Service (or delegate) and the Visiting Clinician and may be undertaken in accord with the following requirements:

- Support person must be 18 years or over.
- Prior agreement of the responsible clinician and the Clinical Manager Perioperative Service / delegate must be obtained and recorded in the patient's medical record.
- **Only one support person may be nominated to be present in the operating room and at all times must obey any instructions given by the Senior Scrub Nurse. Only in *exceptional circumstances* will a second support be permitted to be present following consultation with the Director Clinical Operations and the Clinical Manager Perioperative Service.**
- For emergency caesarean section one support person is permitted in the operating room with the prior approval of the obstetrician.
- For elective caesarean section in which a general anaesthetic is administered a support person is permitted in the operating room after the anaesthetic has been administered and the obstetrician and anaesthetist both indicate their approval.
- The nominated support person must receive prior formal instruction regarding their rights and responsibilities prior to the event and must acknowledge their agreement in writing ATTAC-031. Information will be provided to all patients at the time of booking into Burnside Hospital enabling such instruction to be undertaken during the antenatal period.

4. RECORDING DEVICES IN THE PERIOPERATIVE AND LABOUR AND DELIVERY SUITES

Due to safety considerations support persons must not use video or recording devices of any type (camcorders, mobile phones, etc) in the Perioperative or Labour and Delivery Suites. While digital devices may be used to take still photographs, digital recording is only permitted in the labour ward prior to and following the birth and after all medical interventions have been completed. **At all times support persons must follow the instructions of the hospital staff member, obstetrician or surgeon with regard to the use of any type of camera device.** *(Please refer Clinical Photography Policy POL-141)*

EXPECTED OUTCOME

All surgery (elective or clinically urgent) is undertaken in accord with this policy ensuring patients, support persons, staff and visiting clinicians are not placed at undue risk.

All episodes of clinically urgent surgery fit within the above definition and requirements.

All incidents in which elective surgery is either undertaken or a surgeon seeks to have undertaken outside the above requirements will lead to an incident form being completed and reported to the Chief Executive at the first available opportunity. The Chief Executive will inform the Chairman of the Perioperative Committee who shall be responsible to investigate and instigate any required action to ensure safe working practices are maintained at all times reporting the outcome back to the Chief Executive.

EVALUATION

The absence of breaches of this policy will demonstrate safe care and safe work practice within the Operating Suite and the Labour Ward.

The Perioperative and Perinatal Committees will monitor the implementation and application of the policy and take necessary remedial action when indicated.

ASSOCIATED BURNSIDE HOSPITAL DOCUMENTS:

- Attendance in the Operating Suite during a Casesarean Section ATTAC-031
- Clinical Photography POL-141

REFERENCES

- Work Health & Safety Act (SA) 2012
- Work Health & Safety Regulations (SA) 2012
- AS/NZS ISO 31000:2009 Risk Management – Principles and guidelines

GUIDELINES FOR MANAGING OBSTETRIC EMERGENCIES ORGANISATIONAL DECISION MAKING IN THE PERIOPERATIVE SUITE

First Issued:	April 2007	**Next Review Due:**	August 2024
Cross Reference:	Perioperative Manual Maternity Service Practice Manual	**Standard(s)**	Governance (1). Clinical Deterioration (8)

INTRODUCTION

The Burnside Hospital has declared itself as a Level 4 Perinatal Service as outlined in the Department of Health (SA Health) Standards for Maternal and Neonatal Services in South Australia 2010.

PREAMBLE

In the perioperative suite, all work and activity is structured around the management of the operating list and the daily running requires careful scheduling and regulating of time for Visiting Medical Officers, staff and patients. There are challenging management issues further complicated by multiple stakeholders with conflicting interests, uncertainty regarding the occurrence, timing and duration of surgeries and, issues associated with organisational performance criteria, e.g. utilisation, overtime.

In the perioperative suite, time is controlled and governed through professional judgement about patient safety and interpersonal communication between nurses and doctors. This is especially important in an organisation where there is the potential for obstetric emergencies. Urgent surgeries have to be scheduled as soon as possible to avoid medical complications, morbidity or mortality.

For elective surgery, surgeons decide the order of their list at the time of forwarding it to the Hospital for a booking. For semi-elective (urgent) surgery, ie cases that are not immediately life threatening, time has to be negotiated with the Hospital Coordinator who liaises with the Clinical Manager (or delegate) of the Perioperative Suite. The majority of Category 3 and 4 caesarean sections are managed in this manner.

A Category 1 Caesarean Section may delay the commencement of a scheduled elective operating list or, in extreme circumstances, may interrupt a case already underway.

RANZCOG Classification System is as follows:

- Category 1: Clinically urgent (emergency). Immediate threat to the life of a woman or foetus.
- Category 2: Urgent. Maternal or foetal compromise but not immediately life threatening.
- Category 3: Elective. Needing early delivery but no maternal or foetal compromise.
- Category 4: Elective. At a time to suit the woman and the caesarean section team.

RATIONALE

The aim of these guidelines is to:

ensure that organisational responsiveness in emergency and/or urgent caesarean section (Category 1) decision to delivery meets the Level 4 Perinatal Service delineation criteria of 45 minutes as outlined in the Standards for Maternal & Neonatal Services in South Australia, December 2014

- provide a decision making process which is transparent to all relevant visiting medical practitioners and staff;
- ensure that appropriate and timely communication with both the surgeon, anaesthetist and patient affected by this decision is undertaken;
- ensure that the Hospital monitors and identifies trends regarding the number of occasions and circumstances in which this occurs to:

- reduce any potential clinical risks for the patient, surgeon and the hospital;
- identify improvements that could be made to the process for managing obstetric emergencies; and
- reduce any inconvenience incurred by all the affected parties.

The factors which the Hospital takes into consideration when deciding to interrupt or delay a list can be summarised as follows (this is not an exhaustive list):

- The urgency required to minimise the chance of a poor patient outcome with reference to the RANZCOG Classification System;
- Determination of whether there is a vacant theatre which could be used for the emergency surgery;
- Which surgeons, anaesthetists, if any, are already on site to render assistance if required?
- The anticipated length of the time of the surgery to be performed;
- The number and skill mix of the nursing staff available and where these are to be sourced from at short notice;
- The type of surgery being undertaken in theatres 1 to 5;
- How close is the particular case to completion?
- The length of the operating list to be interrupted;
- The scheduled list start time and estimated finish time;
- Which surgeons have recently, previously been affected by list interruptions and/or delays.

DELEGATED AUTHORITY

For emergency surgery, including emergency caesarean sections, the Clinical Manager of the Perioperative Suite (and or their delegate) is best placed to make the decision about which elective operating session to stop and is authorised by the Hospital to do so.

EXPECTED OUTCOME

All patients classified as requiring a Category 1 Caesarean Section will meet the Level 4 perinatal service delineation criteria as outlined in the Standards for Maternal and Neonatal Services in South Australia 2010.

No other patient currently undergoing a surgical procedure has an adverse outcome as a result of the interruption.

The delay or interruption to a scheduled operating list and/or case is infrequent.

EVALUATION

To be monitored by the Peri-natal and Perioperative Committees.

RELATED BURNSIDE HOSPITAL DOCUMENTS:

Emergency Protocol for Maternal Distress Requiring Immediate LSCS (Category 1) following theatre closure PRT-003

Organisational Responsiveness to Lower Segment Caesarean Section GUID-019

Set up for an Emergency LSCS for Beginners ATTAC-054

REFERENCES

Standards for the Management of Category 1 Caesarean Section in SA November 2011

RANZCOG College Statement, July 2015. Categorisation of Urgency for Caesarean section

Standards for Maternal & Neonatal Services in South Australia, December 2014

INTRODUCTION OF NEW MEDICAL TECHNOLOGIES & TECHNIQUES

First Issued:	December 2005	Next Review Due:	September 2026
Cross Reference:		Section:	Clinical Governance (1)

POLICY

It is the policy of Burnside Hospital that the introduction of new medical technologies and techniques into clinical medical practice at Burnside Hospital shall be undertaken in accord with the attached protocol.

APPLICATION

It is the responsibility of Medical Executive Committee to consider and make recommendations to the Board of Directors in respect of requests for the introduction of new medical technologies and techniques into clinical medical practice in accordance with the ***'Protocol for the Introduction of new medical technologies and techniques into clinical medical practice at Burnside Hospital'*** (PRT-009).

Prior to the purchase of any new or replacement products (consumables or equipment) the Product Evaluation Committee (consumables) or the relevant Clinical Advisory Committee (equipment) is required to conduct a review and develop recommendations for consideration by the relevant Director in accord with the ***Burnside Hospital Delegations Policy***.

EXPECTED OUTCOME

Patient safety and Burnside Hospital safety and viability is not compromised in any regard whatsoever by the introduction of new medical technologies and / or techniques.

EVALUATION

Compliance with this policy is monitored via the relevant clinical committee the activities of which are overseen by the Medical Executive Committee.

Deviations from this policy as reported through Adverse Event, Clinical Issue Alert, Hazard Reporting and/or Incident Monitoring systems (RiskMan).

RELATED POLICIES/REFERENCES

- Delegations Policy (POL-024)
- Incident Management Policy (POL-062)
- Royal Australasian College of Surgeons / ASERNIP-S General Guidelines for Assessing, Approving and Introducing New Surgical Techniques into a Hospital, or Health Service, March 2009.

BURNSIDE HOSPITAL ADMISSION EXCLUSION CRITERIA

First Issued:	February 2015	**Next Review Due:**	September 2024
Cross Reference:	Hospital Policy Manual	**Standards:**	Clnical Governance (1) Recognising & Responding to Clinical Deterioration (8)

PREAMBLE

In the interests of ensuring that the Burnside Hospital (**BH**) is able to deliver an appropriate level of contemporary, safe care to patients, the clinical service profile is established in collaboration with the Board of Directors (**BOD**), the Executive Committee and the Clinical Advisory Committees.

Patient safety at BH is our highest priority and to ensure we achieve this goal, the hospital has well structured assessment and review processes for the admission of all patients in particular, higher-risk patients seeking admission. Exclusion criteria for admission have been developed over many years in the interests of patient safety and endorsed from time to time through the BH clinical advisory committee framework.

POLICY

BH has clearly documented contemporary corporate and clinical governance arrangements in place to ensure the provision of appropriate safe care to patients admitted for acute surgical, medical, obstetric and oncology services. These arrangements are detailed in departmental ***Functional Guidelines*** developed to provide guidance to VMOs considering admission of patients to the BH. These guidelines are consistent with state endorsed guidelines and provide the background and rationale for the patient selection and exclusion criteria.

Exclusion criteria for admission at the BH:

- Patients who require Intensive Care Unit (**ICU**) or Critical Care Unit level of care *(no ICU)*.
- Patients with an acute psychiatric illness and/or an inpatient in an acute psychiatric facility who could not be managed safely in our hospital environment.

  Transfers from an acute inpatient facility who have been assessed as appropriate by both the psychiatric inpatient facility and BH are to have ongoing supervision of the treating psychiatrist during the BH admission. This will be facilitated by urgent temporary credentialing when required. *(Medical Executive Committee – August 2019)*
- Patients at risk of major blood loss, i.e. obstetric patients, who decline blood transfusion *(Medical Executive Committee (**MEC**) - June 2012).*
- Children less than 10 years of age *(MEC - August 2010).*
- Sleep patients under 14 years of age *(MEC - June 2014).*
- Sleep patients who have had ENT surgery within the last eight weeks prior to admission *(Sleep Committee September -2014).*
- Women less than 34 weeks gestation in labour *(Department of Health, Level 4 Perinatal Service Delineation).*
- Women wanting to labour and deliver in water *(BOD November - 2013).*
- Women requesting Lotus Births *(Perinatal Committee – 2007).*
- Women with Placenta Praevia with a high index of suspicion or diagnosed Placenta Accreta, Increta or Percreta *(Perinatal & MEC Committees - October 2007 & revisited at Perinatal Committee – February 2015).*
- Women with Placenta Praevia positioned over a uterine scar *(Perinatal Committee – February 2015).*
- Women with higher order pregnancies, i.e. triplets *(Department of Health, Level 4 Perinatal Service Delineation).*

- Women with a BMI of 45 or greater at the 34 to 36 week gestational obstetric visit. *(MEC- March 2017)*
- Any other patient deemed not appropriate by the treating surgeon and/or anaesthetist and/or physician and/or intensivist.
- Any other patient deemed not appropriate by the Director Clinical Operations and/or Chief Executive Officer.

IMPLEMENTATION

BH has an approved High Dependency Unit and provides 24 hour, 7 days a week support from a group of Intensive Care Specialists.

Visiting Medical Officers (**VMOs**) who wish to treat patients at BH should be aware of the limitations of services available at the hospital and this must form part of the pre-operative risk assessment as to any decision to admit a patient to the Hospital.

Limitations should be discussed with patients and any other relevant treating medical practitioners in the treating team. These discussions must be documented in the medical record.

EVALUATION

The review and analysis of mortality and morbidity data arising from the reporting of adverse events and incidents by the hospital's Part 7 Committee – The Clinical Review Committee, will inform the organization of any requirement to review clinical protocols or admission criteria.

EXPECTED OUTCOME

BH will admit and manage accredited VMOs appropriate patients within its current service capability.

ASSOCIATED BURNSIDE HOSPITAL DOCUMENTS:

Brian Fricker Oncology Functional Guidelines INT-003

High Dependency Unit Functional Guidelines INT-004

Maternity Unit Functional Guidelines INT-005

Short Stay Procedure Unit Functional Guidelines INT-006

Von Rieben Functional Guidelines INT-007

Medical Staff By-laws and Rules for Visiting Medical Officers RES-054

Letter of 25th June 2014 to VMOs from the Chairman of the Clinical Review Committee, Dr G.D. Martin, Re: *Suitability of patients for surgery/arrangements of early pre-anaesthetic consultation/assessment with the responsible Anaesthetist & provision of a written consultation/assessment report and recommendations to the admitting Clinician, copied to BH Admission and where appropriate discussed with the duty Intensivist, prior to admission.*

REFERENCES

Australian Commission on Safety & Quality in Health Care (ACSQHC), Standard 1: Clinical Governance *(website accessed August 2019)*

Australian Commission on Safety & Quality in Health Care (ACSQHC). Standard 8: Recognising & Responding to Clinical Deterioration *(website accessed August 2019)*

Australian Commission on Safety & Quality in Health Care (ACSQHC), Advisory 19/01; Recognising & Responding to Acute Deterioration Standard: Recognising deterioration in a person's mental state. April 2019

Australian & New Zealand College of Anaesthetists (ANZCA) – *Statement on Roles in Anaesthesia and Perioperative Care* – PS59 2015.

Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia*, March 2014.

Royal Australasian College of Surgeons (RACS), Code of Conduct.

Finding of Inquest, February 2014, *RYAN, John William & WALTON, Patricia Dawn, Recommendation 5 p.88*, Coroners Court of South Australia.

CLINICAL PRIVILEGES REVIEW COMMITTEE (CRPC)

TERMS OF REFERENCE

The function of the Clinical Privileges Review Committee (CPRC) is to review new and renewal applications for Visiting Medical Officers (VMO) and Allied Health Professionals (AHPs) Clinical Privileges at Burnside Hospital (BH). The committee is also responsible for monitoring and reviewing the professional performance of accredited VMOs and AHPs.

The CPRC shall be responsible for:

1. Reviewing documentary and other evidence provided by the applicants as to their suitability for accreditation to BH. Such documentation should demonstrate the following:
   - Professional registration held and current entitlement to practise
   - Qualifications and training including undergraduate, postgraduate and special training with respect to the privileges requested
   - Recent clinical experience and competence in the field of expertise in which privileges are sought;
   - That the applicant has subjected and will continue to subject the results of clinical work to quality assurance mechanisms including clinical audit and peer review processes
   - Commitment to past and continuing professional education
   - Satisfactory professional referee reports including peer comments which demonstrate that the applicant has and maintains the confidence of his peers
   - Acceptable and safe practice as evidenced by personal history of complaints, professional body investigations, indemnity and legal records.
2. The administration of those sections of the Accredited Practitioner By-Laws as outlined below:
   - Section 8: Procedure for Consideration of and Granting of Accreditation to BH
   - Section 9: Delineation of Clinical Responsibilities
   - Section 10: Corrective Action

RESPONSIBLE TO:

The Board of Directors

MEMBERSHIP:

Membership shall comprise representatives of the colleges whose members are granted clinical privileges at BH. As such they should include, where possible, representatives from the following professional groups:

- Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG)
- Royal Australasian College of Surgeons (RACS)
- Royal Australasian College of Physicians (RACP)
- Royal Australian College of General Practitioners (RACGP)
- Australian and New Zealand College of Anaesthetists (ANZCA)
- Royal College of Pathologists of Australasia (RCPA)
- Chief Executive Officer (CEO)
- Director Clinical Operations (DCO)
- Quality, Safety and Risk Manager (QSRM)
- Ex Officio Member: Chair, BH Board of Directors (BOD)

QUORUM

A quorum shall consist of one half of the members plus one provided that at least three medical representatives and a representative of the hospital are present.

Frequency of Meetings:

The CPRC shall meet every three (3) months and at other times as deemed necessary by the Chair.

CONFLICT OF INTEREST

Each committee member is required to bring to the attention of the Chair of the meeting any actual, perceived or potential conflict of interest which he or she may have with any item on the agenda for that meeting.

The other members (excluding that disclosing member and any other conflicted member) must then decide whether or not any of those who have been excluded should:

- vote on the matter
- participate in any debate on the matter, or
- be present during the debate and/or the voting.

The meeting must then proceed in accordance with that decision.

OFFICE BEARERS

Chair

The committee shall elect from its membership by simple majority a chair who shall hold office for a period of up to three years following which a new election shall be undertaken.

Secretary

The Executive Assistant shall be responsible for providing administrative support to the CPRC including the preparation of agendas and the recording of minutes of meetings.

Members

Members must be appointed by appropriate qualifications and expertise.

Voting

All members will have equal right to cast one vote on items moved during a meeting.

Replacing Committee Members

New membership will be through nomination and selection by presiding members of the committee on an as needs basis, with preference being given to VMOs who demonstrate commitment to the BH as evidenced by their significant throughput of patients.

Executive

An Executive comprising the Chair, CEO and DCO or their nominees shall be empowered to consider and respond to issues between meetings provided that such matters are reported to the first available meeting of the committee. Decisions of the Executive shall be considered interim until ratified by the committee.

Recording of Proceedings

Where practicable, the agenda together with reports and documents that relate to the CPRC will be forwarded to members in sufficient time to enable consideration prior to meetings.

Accurate minutes will be kept of each meeting of the CPRC. The minutes of meetings shall be forwarded to committee members for ratification at the next subsequent meeting of the committee. When confirmed, the minutes shall be signed by the chair. All meeting documentation must be handed to the secretary for confidential disposal at the conclusion of the meeting.

REVIEW:

Terms of Reference shall be reviewed annually and endorsed by the BOD.