# THE BURNSIDE WAR MEMORIAL HOSPITAL INC.

# ACCREDITED PRACTITIONER BY-LAWS

The Burnside War Memorial Hospital Inc

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## 1. INTRODUCTION

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

Burnside Hospital's 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.

Burnside Hospital 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 Board of Directors (BOD) of the Burnside Hospital (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 the appointment process ensuring that only those providers who meet the selection criteria and who have the relevant credentials will be considered for appointment.

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 initial granting of clinical privileges for all professional health care providers and the ongoing revalidation/review of these clinical privileges as required. They define the relationship between the hospital and Accredited Practitioners and are designed to protect the interests of BH, its patients and Accredited Practitioners.

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 BH BOD on the advice of the Medical Executive Committee and/or Clinical Privileges Review Committee.

The appointment process for visiting practitioners will consider performance and reflect on the organisational capabilities of BH.

The Clinical Privileges Review Committee (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 the Burnside Hospital. The committee is also responsible for monitoring and reviewing the professional performance of Accredited Practitioners and Allied Health Professionals.

Individuals involved in the appointment 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.

These rules are intended to provide for the provision of medical and dental services, the granting of clinical privileges in respect of those services, and the relationship between BH and Accredited Practitioners.

## 3. DEFINITIONS

***Accreditation*** means the authorisation in writing conferred on a person by the Chief Executive Officer (CEO) to deliver medical, surgical, dental or other services to patients at Burnside Hospital (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 3)
- The policies and procedures of the hospital
- 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:

- The hospital and its operation
- The support services, staff profile, minimum standards and other requirements to be met in the hospital
- 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 or other stage equivalent.

***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 the hospital.

***Board of Directors*** (BOD) means the Board of Directors, the governing body of the Burnside War Memorial Hospital.

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

***Burnside War Memorial Hospital Inc.*** means the Burnside Hospital herein known as BH.

***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 Board, or their delegate approved by the Board, 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 3, 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*** heareinafter known as the CPRC means a sub-committee of the BOD that has multidisciplinary membership, established by the BH in accordance with these By-laws to perform the following functions:

- Appointment 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*** herein known as the 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.

***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.

***Hospital*** shall mean the Burnside War Memorial Hospital (hereinafter known as BH).

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

***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 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.

***Temporary Appointment*** means an appointment of an Accredited Practitioner for a specified period of less than 90 days as determined by the Chief Executive Officer.

***Unprofessional Conduct*** 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 the hospital 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 this document is to set out the terms and conditions on which practitioners are to be accredited to admit patients and to care for and treat patients at Burnside Hospital. Every applicant is required to be provided with a copy of this document.

These By-laws:

- Establish the principles which apply to the accreditation of Medical and Dental Practitioners at BH
- Govern the relationship of BH with its Accredited Practitioners
- Set out rules for the conduct of Accredited Practitioners at BH
- Provide for the establishment of structures within BH which are necessary for the delivery of high-quality care to its patients
- Outline BH requirements of Accredited Practitioners in relation to the safety and quality of care of its patients
- Ensure that all Accredited Practitioners appointed to practice in BH have an acceptable level of knowledge, skills, attitudes and competence consistent with standards established by their registering professional body (or equivalent) and are practising safely and to a standard acceptable to the BH
- Ensure that all patients admitted to BH receive optimal care and to encourage a high level of professional performance by all Medical Practitioners and Dentists accredited to practice in BH
- Provide a means of self-regulation and advice on delineation of clinical privileges, initial appointment and ongoing revalidation/review of these clinical privileges
- Provide an instrument for members to discuss issues affecting practitioners and to maintain clear lines of communication from and to individual members
- Facilitate Accredited Practitioners undertaking any other responsibilities agreed upon by the BOD.

The responsibility for the application of these By-laws is vested in the CEO of BH.

The Board of Directors and the Clinical Privileges Review Committee (CPRC) has the responsibility to oversee and monitor the diligent application of these By-laws. Members of these committees shall in carrying out their roles, act in accordance with these By-laws and in the best interests of the Hospital.

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 environment.

## 5. PRIVACY AND CONFIDENTIALITY

### 5.1 Privacy

Accredited Practitioners will manage, and assist the Hospital 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 the 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 kept 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, copying it, reproducing it or making it public.

### 5.5 When confidentiality can be breached

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 APPOINTMENT OF ACCREDITED PRACTITIONERS

The Accredited Practitioner By-laws prescribe the terms and conditions upon which practitioners are 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 set out what is regarded as being current acceptable medical/dental practice.

Although basic ethical considerations do not alter, the By-laws can be amended at the discretion of the BH, for example due to a change in ethical standards within the profession. This may result in alteration or modification to these rules. When, and if such changes should occur, they will be made known to all concerned.

It is expected as a matter of course that all Accredited Practitioners will adhere to the highest principles of medical ethics in their relation 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.

The BH Schedule of Covenants (Attachment 2) summarise the Terms and Conditions of Appointment to the BH. All Practitioners are expected to be familiar with these Covenants which are provided to Accredited Practitioners on appointment.

### 6.1 Conditions applicable to all Accredited Practitioner Appointments

An Appointment 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 General

Accredited Practitioners must:

(a) Comply with their authorised Scope of Clinical Practice

(b) Comply with the BH Code of Conduct (Attachment 3)

(c) Be familiar with the BH Schedule of Covenants summarised Terms and Conditions of Appointment to the Hospital (Attachment 2)

(d) Comply with all applicable legislation and general law

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

(f) 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 suspension or termination), refer to By-laws 6.17, 10.2 and 10.3

(g) If theatre sessions have been requested by the Accredited Practitioner and allocated, then the Accredited Practitioner must in the main utilise the theatre sessions effectively. (Refer also By-law 6.9 Conduct of Surgery).

The Hospital reserves the right to:

(i) modify or change the allocation of theatre sessions having regard to the utilisation and hospital requirements

(ii) make casual bookings for the whole or part of any operating room session which is not fully utilised.

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

(i) 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, Hospital employees and patients

(j) 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 the Hospital

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

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

(m) 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

(n) Participate in craft group structures which may be established

(o) 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)

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

(q) 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.

### 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 the Hospital. 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 7)

(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 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 Practitioners 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 the Hospital 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 the Hospital 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 the 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 Director Clinical Operations 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 the 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 the 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 the Hospital'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 Accredited Treating 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 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**

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.

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

(b) 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.

(c) 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, Standard 9.9: Enabling patients, families and carers to initiate an escalation of care response. *(CEC 2011)*

(d) 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 the Hospital 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 the 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 the Hospital'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 4) and the Guidelines for Managing Obstetric Emergencies Organisational Decision Making in the Operating Suite (GUID-020) (Attachment 5) 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 the Hospital 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 him 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 Practitioners 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 the Hospital'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 the Hospital must maintain a level of professional indemnity insurance:

(a) Which covers all potential liability of the Accredited Practitioner in respect of the Hospital 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.

### 6.15 Annual Disclosure

Accredited Practitioners must furnish annually to the 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 the Hospital

(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 6.15, 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 Appointment to 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 appointment of Accredited Practitioners is conditional on the person satisfactorily completing any checks that BH may require for the purpose of fulfilling BH 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 Practitioners 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 or engagement 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 Leave**

Where Accreditation has been granted in respect of BH, an Accredited Practitioner must use their best endeavours to notify the CEO in writing, at least 4 weeks in advance of holidays, 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 Practitioners will be accommodated, every reasonable effort will be made to do so within the hospital's financial resources.

All applicants for appointment to BH 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 the hospital 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**

In accordance with the *Work Health Safety Act, (SA) 2012*, 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, Accredited Practitioners shall take reasonable care of the health and safety of themselves and others who may be affected by their acts or omissions.

They 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, 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 the hospital's fire and emergency procedures at the time of commencing practice at the hospital and thereafter as requested by the hospital. See also By-law 6.13.

The above is not intended to be an exhaustive statement of BHs 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 the hospital 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 the Burnside Hospital in meeting its obligations under the HPPA's as advised by either the Burnside Hospital 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 the hospital'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 Clinical Privileges Review Committee (CPRC) and/or the Medical Executive Committee (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).

## 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-law 6.9

(iii) 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

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

(v) No right of 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 to review 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 Tenure**

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

Appointments are ordinarily 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 Board 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 appointments may be required to serve a one year probationary period.

**8.3 Temporary Privileges (Locums and Short Terms Appointments)**

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

**8.4 Processing of Applications**

The application shall be forwarded to the BH CEO for processing following which it will be presented to the CPRC (Attachment 9, 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 BH Medical Executive Committee

(b) A nominee of the BH 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 shall 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 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 shall 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 shall 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 shall be notified to the applicant in writing. A copy of the BH Schedule of Covenants (Attachment 2) in place from time to time shall be included with the initial letter of appointment.

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

### 8.5 Re-appointment Procedure

The BH will generally endeavour to notify Accredited Practitioners of the end of tenure 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-appointment 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 appointment.

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

In addition to the required demographic information (see application form) an individual's professional performance, peer recommendations and other indicators of current competence will 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 appointment.

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 tenure 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 below.

### 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 the applicant

(c) At the request of the DCO, CEO, chairman of the MEC or CPRC or the individual practitioner to whom the privileges apply.

A review of clinical privileges may be appropriate when there are indicators of decreasing clinical competence such as outdated practices, clinical disinterest or poor outcomes. However disciplinary matters will be managed through the appropriate performance management channels by the CEO or their nominee.

## 9 DELINEATION OF CLINICAL RESPONSIBILITIES

Each application for appointment or re-appointment 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 is responsible for recruiting 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 is granted clinical privileges by the BH. (Refer By-law 8.3) Completion of Short Term Appointment form is required.

## 10. CORRECTIVE ACTION

### 10.1 Complaint/Review Process

(a) Whenever the activities or professional conduct of any Accredited Practitioner with clinical privileges raise issues of:

(i) detriment to patient safety

(ii) inadequate patient care

(iii) disruption to BH operation

(iv) a breach of the Schedule of Covenants.

A complaint against such a practitioner may be initiated by a credentialed Accredited Practitioner, a chair or member of a clinical advisory committee, a member of the BOD to the CEO or by the CEO on their own instigation.

(b) Upon receipt of such a complaint, or on their own instigation, the CEO shall facilitate a group of two or three of the Accredited Practitioner’s peers to discuss the subject of the complaint with the Accredited Practitioner.

(c) Following such discussion, the peer group shall report to the CEO on the outcome of their meeting, covering:

(i) their assessment of the complaint

(ii) the Accredited Practitioner's response to the complaint

(iii) their recommendations on whether or not further action should be taken. Further action may include but is not limited to suspension, revocation or amendment to the privileges.

(d) Upon receipt of such recommendation, the CEO shall place before the BOD the recommendation and at its next meeting the BOD shall make a decision whether or not to adopt the recommendation of the peer group.

(e) The Accredited Practitioner shall be notified in writing of the decision of the BOD. The Accredited Practitioner will be notified of the reasons, if within 14 days of being informed of the decision, the Accredited Practitioner requests this information.

(f) If within 14 days of being notified of the BOD decision or receiving reasons as the case may be, the Accredited Practitioner notifies in writing the CEO that the practitioner is aggrieved with the decision, the matter will be referred to the CPRC. Such referral shall not automatically operate as a stay of the Board of Director's decision.

(g) The CPRC shall notify the practitioner of a hearing date to occur within 30 days.

(h) At such a hearing:

(i) the CEO or their nominee shall place before the CPRC all the information considered relevant to the complaint and the decision of the BOD. The information shall also be provided to the Accredited Practitioner in so far as it has not already been provided in advance of the hearing

(ii) the Accredited Practitioner will be at liberty to place before the CPRC such additional information as the Accredited Practitioner wishes to be considered by the CPRC

(iii) the CPRC may ask the Accredited Practitioner questions in relation to the subject matter of the complaint and decision. The practitioner shall not be obliged to answer such questions, but any failure to do so may be factored into the deliberations of the CPRC and taken into account by the CPRC

(iv) the Accredited Practitioner has the right to be accompanied by a professional colleague or other support person of their choosing

(v) the Accredited Practitioner is not entitled to be accompanied by a legal practitioner unless the CPRC consents, which consent may be granted unconditionally or conditionally or refused in the absolute and unfettered discretion of the CPRC.

(i) At the conclusion of the hearing, the CPRC shall furnish to the BOD in writing its recommendations.

(j) Upon receipt of such recommendations and at the next regular scheduled meeting of the BOD, the BOD shall consider the recommendation. If it is the preliminary view of the BOD not to accept the recommendation of the CPRC, then the officers of the CPRC and the BOD shall meet jointly to discuss the matter.

(k) Once the BOD makes a final decision in relation to the recommendation of the CPRC, notification of that decision shall be sent by the CEO to the Accredited Practitioner involved. The BOD may make its own

decision in its absolute discretion even if it is not in relation to the recommendation of the CPRC. The BOD's decision may include suspension, revocation or amendment of privileges.

(l) The decision of the BOD shall be final and there is no right of appeal therefrom.

**10.2 Summary Suspension**

(a) Following consultation with the Chairman of the BOD and with either the Chairman of the CPRC or the Chairman of the MEC, the CEO has the authority whenever it is considered that action must be taken immediately in the best interest of patient care in BH, to suspend summarily all or any portion of clinical privileges of a practitioner.

(b) Such summary suspension shall become effective immediately upon imposition.

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

(d) As soon as possible after the suspension has been imposed, the CPRC shall be advised of such action. Within 30 days of receipt of such notification, the CPRC will hold a hearing to review the suspension.

(e) At such a hearing:

(i) the CEO or their nominee shall place before the CPRC all the information considered relevant to the suspension

(ii) the Accredited Practitioner will be at liberty to place before the CPRC such additional information as the Accredited Practitioner wishes to be considered by the CPRC

(iii) the CPRC may ask the Accredited Practitioner questions in relation to the subject matter of the suspension. The Accredited Practitioner shall not be obliged to answer such questions, but any failure to do so may be factored into the deliberations of the CPRC and the decision it reaches

(iv) the Accredited Practitioner has the right to be accompanied by a professional colleague of their choosing

(v) the Accredited Practitioner is not entitled to be accompanied by a legal practitioner unless the CPRC consents, which consent may be granted unconditionally or conditionally or refused in the absolute and unfettered discretion of the CPRC.

(f) At the conclusion of the hearing, the CPRC shall furnish to the BOD in writing its recommendations.

(g) Upon receipt of such recommendations and at the next regular scheduled meeting of the BOD, the BOD shall consider the recommendation. If it is the preliminary view of the BOD not to accept the recommendation of the CPRC, then the officers of the CPRC and the BOD shall meet jointly to discuss the matter.

(h) Once the BOD makes a final decision in relation to the recommendation of the CPRC, notification of that decision shall be sent by the CEO to the Accredited Practitioner involved. The BOD may make its own decision in its absolute discretion even if it is not in relation to the recommendation of the CPRC. The BOD's decision may include revocation of clinical privileges.

(i) The decision of the BOD shall be final and there is no right of appeal therefrom.

### 10.3 Automatic Suspension

(a) Clinical privileges 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. Should the professional registration of the suspended member be re-instated during the period of time that a clinical privilege has been granted by BH, privileges may be re-instated by the BOD.

(b) Suspension of clinical privileges may also be warranted in the event that there is a breach of the Schedule of Covenants, for example failing to maintain appropriate professional indemnity insurance.

(c) Notice of suspension of clinical privileges will be made in writing and forwarded to the BOD.

(d) If the decision of the BOD supports the recommendation of the CPRC, and the practitioner is aggrieved by that decision, then the affected practitioner has the right of appeal. Such appeal must be lodged within 14 days of the date of such advice.

(e) Upon lodgement of an appeal by the aggrieved practitioner, the CPRC shall be advised of such action within 30 days of its lodgement and shall hold a hearing to review the reduction of suspension of clinical privileges.

(f) At such a hearing:

(i) the CEO or their nominee shall place before the CPRC all the information considered relevant to the suspension

(ii) the Accredited Practitioner will be at liberty to place before the CPRC such additional information as the Accredited Practitioner wishes to be considered by the CPRC

(iii) the CPRC may ask the Accredited Practitioner questions in relation to the subject matter of the suspension. The Accredited Practitioner shall not be obliged to answer such questions, but any failure to do so may be factored into the deliberations of the CPRC and the decision it reaches

(iv) the Accredited Practitioner has the right to be accompanied by a professional colleague of their choosing

(v) the Accredited Practitioner is not entitled to be accompanied by a legal practitioner unless the CPRC consents, which consent may be granted unconditionally or conditionally or refused in the absolute and unfettered discretion of the CPRC.

## 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 Board of Directors prior to implementation. Changes to the By-laws shall come into force at the date on which the Board's approval is assigned to the document by way of the signature of the Chairman of the Board of Directors.

| | |
|---|---|
| ***Mr Frank Kite*** | ***Justice David Berman*** |
| *Chairman, Board of Directors* | *Chairman, Governance Committee* |
| ***Dr Lino Scopacasa*** | ***Ms Heather Messenger*** |
| *Medical Officer Representative* | *Chief Executive Officer* |

***Approved by: Burnside War Memorial Hospital's Board of Directors, 29 July 2015***

***ASSOCIATED BURNSIDE HOSPITAL DOCUMENTS:***

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

***Attachment 2:***
*ATTAC-100* *Burnside Hospital Schedule of Covenants*

*Attachment 3:*
*ATTAC-022* *Burnside Hospital Code of Conduct*

***Attachment 4:***
*POL-071* *Safe Work Practices (Perioperative Suite and Labour Ward)*

***Attachment 5:***
*GUID-020* *Guidelines for Managing Obstetric Emergencies Organisational Decision Making in the Operating Suite*

***Attachment 6:***
*POL-031* *Introduction of New Medical Technologies and Techniques*

***Attachment 7:***
*POL-154* *Burnside Hospital Admission Exclusion Criteria*

***Attachment 8:***
*TOR-013* *Clinical Privileges Review Committee (CPRC) Terms of Reference*

***REFERENCES*:**


- Standard for Credentialing & Defining the Scope of Clinical Practice of Medical Practitioners for use in public & private hospitals, 2004. Australian Commission for Quality & Safety in Health care
- Australian Council for Healthcare Standards, Accreditation Guidelines – EQuIPNational effective January 2013
- Australian Commission for Safety & Quality in Healthcare, National Safety and Quality Health Service Standards, Standard 1, Governance for Safety and Quality in Health Service Organisations, October 2012


***RELEVANT LEGISLATION AND AUSTRALIAN STANDARDS FOR INFORMATION:***

Consent to Medical Treatment and Palliative Care Act (SA), 1995

- Controlled Substances Act 1984
- Health Care Act (SA) 2008
- Health Practitioner Regulation National Law (South Australia) 2010
- Mental Health Act 2009
- Work Health and Safety Act (SA) 2012
- AS/NZS ISO 31000:2009 Risk Management – Principles and Guidelines
- AS4187:2014: Reprocessing of reusable medical devices in health service organisations
- Clinical Excellence Commission, Partnering with Patients, Patient and Family Escalation of Care 2011

*Please note that this list is not exhaustive and may be changed or added to at anytime.*