By-Laws for Accredited Practitioners

Approved by Nexus Hospitals Chief Executive Officer
23 July 2024

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This document sets out what are described as the current ‘By-Laws’ for use at hospitals and facilities owned or operated by Nexus Day Hospitals Pty Ltd and its subsidiaries **(Nexus)**.

These By- Laws cover the following Nexus Facilities:

Facility	Address
Albany Day Hospital	6 Lubich Way Mira Mar WA
Bondi Junction Private Hospital	1/21 Spring St Bondi Junction NSW
Bundaberg Private Hospital	51 Commercial St Kensington Bundaberg QLD
Bunbury Day Hospital	140 Spencer St South Bunbury WA
Canberra Private Hospital	70 Kent St Deakin ACT
Charlestown Private Hospital	250 Pacific Highway Charlestown NSW
Corymbia House Day Hospital	92 David St Dandenong VIC
Hobart Day Surgery	10 Warneford St Hobart TAS
Insight Private Hospital	Level 5 470 Wodonga Place Albury NSW
Kogarah Private Hospital	1/1 Derby St Kogarah NSW
Manningham Private Hospital	3/200 High St Templestowe Lower VIC
North Lakes Day Hospital (includes North Lakes Haematology & Oncology)	7 Endeavour Blvd North Lakes QLD
Oxford Day Surgery	416-418 Oxford St Mt Hawthorn WA
Pacific Private Day Hospital	Level 1 123 Nerang St Southport QLD
Pennant Hills Day Surgery	361 Pennant Hills Rd Pennant Hills NSW
Rosemont Endoscopy Centre	56 Rosemont St Wollongong NSW
Samford Rd Day Hospital	383-391 Samford Rd Gaythorne QLD
Southbank Day Surgery	38 Meadowvale St South Perth WA
Sundew Day Surgery	24 Sundew Rise Joondalup WA
Sunshine Coast Haematology & Oncology Clinic	10 King St Buderim QLD
Tennyson Centre Day Hospital	Level 1 520 South Rd Kurralta Park SA
Vermont Private Hospital	645-647 Burwood Highway Vermont South VIC
Warringah Day Surgery	10 Dale St Brookvale NSW
Westside Haematology & Oncology	Level 3 32 Morrow St Taringa QLD
Westside Private Hospital	Level 1 32 Morrow St Taringa QLD
Western Haematology & Oncology Clinic	18 Prowse St West Perth WA
Windsor Private Hospital	20 The Avenue Windsor VIC

Section 1

THESE BY-LAWS

THESE BY-LAWS:

What are these By-Laws?

1. These By-Laws are created by Nexus Day Hospitals Pty Ltd Executive and approved by its Chief Executive Officer (CEO).
2. These By-Laws are adopted in every Facility operated by Nexus
3. These By-Laws are intended for use by, and apply to, Accredited Practitioners who hold Accreditation with respect to a particular Facility owned or operated by Nexus and set out the standards and requirements to be followed to ensure continued Accreditation.

How are these By-Laws changed?

4. These By-Laws may be changed at the direction of the CEO.
5. Every change to these By-Laws takes effect from the time of approval by the CEO.

What are the purposes of these By-Laws?

These By-Laws have many purposes, including to:

6. Serve to maintain Nexus's clinical governance framework and improve the safety and quality of its service delivery;
7. Ensure that the environment in which hospital, medical and clinical services are delivered supports and facilitates safety and quality;
8. Defines the relationship between Nexus and its Accredited Practitioners;
9. Set out the circumstances in which Medical Practitioners, Dentists, Allied Health Professionals and other approved categories of health professional may be eligible to apply to be Accredited within the defined Scope of Clinical Practice granted, the basis upon which a successful applicant may admit, care for and treat patients at a Facility, and the circumstances in which accreditation may be revoked;
10. Assist in compliance with Commonwealth and State/Territory laws, regulations and standards, including the 'Standard for Credentialing and Defining the Scope of Clinical Practice' and the National Safety and Quality Health Service Standards as defined by the Australian Commission for Safety and Quality in Health Care (ACSQHC); Clinical Services Capability Frameworks, and other similar State/Territory frameworks and legislation.

What do the By-Laws contain?

11. These By-Laws reflect the current environment in which Nexus is operating. Changes to the law, altered perceptions of clinical best practice, the economic and risk environments in which health care is delivered and the governance structures (both clinical and corporate) of Nexus are all factors which influence the By-Laws and their implementation.
12. These By-Laws contain the following:
    a. The circumstances in which applicants will be eligible to be credentialed and the circumstances in which accreditation may be revoked;
    b. The processes by which accreditation may be granted and defining the Scope of Clinical Practice of Accredited Practitioners;
    c. The role of the Medical Advisory Committee and its sub-committees in the processes of accreditation at Nexus Day Hospitals;
    d. The ongoing clinical, behavioural and other responsibilities of Accredited Practitioners in relation to continuing eligibility to be Accredited.

13. Every applicant for accreditation will review these By-Laws and Annexures before making an application. It is an expectation that these By-Laws are read in their entirety by the applicant as part of the application process. Ignorance of the By-Laws will not be regarded as an acceptable excuse for non-compliance with continuing eligibility requirements. It is a requirement for continued eligibility for accreditation that Accredited Practitioners comply with the By-Laws at all times when admitting, caring for or treating patients, or otherwise providing services at the Facility. Any non-compliance with the By-Laws may be grounds for suspension, termination or imposition of conditions with respect to accreditation.
14. Unless specifically determined otherwise by the CEO and advised in writing for a specified Accredited Practitioner, the provisions of these By-Laws in their entirety prevail to the extent of any inconsistency with any terms, express or implied, in a contract of employment or engagement that may be entered into. In the absence of a specific written determination by the CEO it is a condition of ongoing accreditation that the Accredited Practitioner agrees that the provisions of these By-Laws prevail.

What these By-Laws are not

15. Although these By-Laws refer to specific policies that have a direct relevance to the processes of accreditation and defining an Accredited Practitioner's Scope of Practice, these By-Laws do not:
    a. Communicate every policy of Nexus; or
    b. Prevent the CEO or Nexus executive from making decisions that will have an effect on these By-Laws.

Section 2

MEDICAL ADVISORY COMMITTEE

MEDICAL ADVISORY COMMITTEE (MAC)

16. The purposes of the MAC is to:
    a. Advise the General Manager/Director of Nursing (GM/DON) with respect to the clinical and related issues placed before it;
    b. Provide a representative forum for communication from and on behalf of Facility management and vice versa to Accredited Practitioners;
    c. Inform Facility management with respect to matters of clinical safety and quality of care that require expert review, whether this be either the Facility's own clinical governance committees or to external authorities or professional organisations;
    d. To review clinical outcomes and make recommendation on any clinical variation in practice;
    e. The MAC (and every sub-committee of it) has the powers, authorities and responsibilities delegated to it by the Nexus executive and Facility management;
    f. The MAC (and any subcommittees, for example the Credentialing Committee) will be subject to specific 'Terms of Reference' that give guidance both to the duties of the MAC and the administrative rules under which they are to be undertaken;
    g. The MAC may appoint a sub-committee to investigate or consider any matter that has come before it. The members of the sub-committee, and other administrative matters concerning that sub-committee, will be determined by the Facility GM/DON in consultation with the Chairperson of the MAC; and
    h. Notwithstanding the matters set out above in this By-Law, if the CEO in discussion with the Nexus Hospitals Chief Medical Officer (CMO) and Facility GM/DON considers that the MAC is inappropriate or insufficient for any reason, the CEO may create another committee for this specific purpose. The members of the newly created committee are not limited to Accredited Practitioners. The CEO may determine the powers, authorities and responsibilities that are delegated to that committee and the administrative rules they are to operate under.
    i. The Frequency of MAC meetings will be outlined in their terms of reference and will comply with State and Territory government requirements.

Members of MAC

17. The membership of the MAC will be established and constituted in accordance with regulatory requirements of the relevant State or Territory in which the Facility is based, with more specific requirements set out in the relevant Nexus Hospitals policies.
18. The Nexus Hospitals CMO has the power of veto over an appointment to the MAC and may by written notice remove a member from a MAC.
19. Executive representatives from Nexus Hospitals and/or the Facility may attend MAC meetings, but will not have a voting right with respect to decisions to be made by the MAC.
20. The GM/DON may appoint one or more external persons including consumer representatives (who are not Accredited Practitioners) to the MAC. This can be for a specific time or issue, or generally if the GM/DON or CMO considers that the MAC requires their assistance.

Indemnity to Members of Committees

21. Nexus will keep the members of the MAC and its committees indemnified against every cost, claim and demand which is made against any of them in relation to the performance of their functions on a committee, provided that:
    a. They have performed their functions in good faith and without demonstrated malice;
    b. They have acted in accordance with the terms of reference of the committee and the requirements of these By-Laws; and
    c. They maintain confidentiality of any conversation, materials, Accredited Practitioner and patient (or other) outcomes made available for committee review, other than circumstances which legally require disclosure of that confidential information or document.

Section 3

ACCREDITATION

ACCREDITATION

Generally

22. The GM/DON (as delegate of the CEO), following consideration of the recommendation from the Credentialing Committee (or MAC, where a separate Credentialing Committee has not been established), may in his/her complete discretion decide to authorise an applicant for Accreditation to utilise a Facility for the treatment of patients, if he/she is satisfied as to all of the following:
    a. That the Scope of Clinical Practice sought is supported by adequate credentials of the medical practitioner or dentist;
    b. That the applicant agrees to comply with these By-Laws, as well as policies, procedures and administrative processes of Nexus and the Facility;
    c. That the Facility is able and willing to provide appropriate staff, resources and support for the Scope of Clinical Practice sought, referred to as organisational capability and organisational need;
    d. That the Scope of Clinical Practice sought and each treatment of a patient is amenable to the safe and efficient functioning of the Facility; and
    e. Any other considerations the GM/DON determines to be relevant to the application.

GM DON Approval and Scope of Clinical Practice

23. An Accredited Practitioner may only utilise the facilities of Nexus Hospitals within their approved Scope of Clinical Practice and whilst they have the continuing authority from the GM/DON. The GM/DON will consider guidance from the Nexus CMO or Nexus Clinical Governance Committee as appropriate.

Change in Scope of Clinical Practice and Introduction of new clinical services

24. If an Accredited Practitioner is contemplating a change (including expansion) in Scope of Clinical Practice or to perform a new clinical service, an application must be submitted and approved, with the process to be followed as per an application for accreditation and these By-Laws.

Re-accreditation

25. Accredited Practitioners are required to reapply for accreditation prior to the expiration of their existing accreditation, and must obtain approval for re-accreditation in accordance with the requirements and processes set out in these By-Laws.

Nature of Appointment

26. The following applies following successful accreditation or re-accreditation:
    a. Accredited Practitioners who have received accreditation pursuant to the By-Laws may on each occasion make a request for access to facilities and resources for the treatment and care of their patients at the Facility, within the limits of the defined Scope of Clinical Practice attached to such accreditation, and to utilise facilities and resources provided by the Facility for that purpose, subject to the provisions of these By-Laws, Nexus and Facility policies, resource limitations, and in accordance with the organisational need and organisational capability of the Facility;
    b. The decision to grant access to facilities and resources for the treatment and care of an Accredited Practitioner's patients is on each occasion within the sole discretion of the GM/DON and the grant of accreditation contains no conferral of, or general expectation relating to, a 'right of access' to the Facility or its resources;
    c. An Accredited Practitioner's use of the facilities for the treatment and care of patients is limited to the Scope of Clinical Practice granted and subject to the conditions upon which the Scope of Clinical Practice is granted, resource limitations, and the organisational need and organisational capability of the Facility. Accredited Practitioners acknowledge that admission or treatment of a particular patient is subject always to bed availability, the availability or adequacy of nursing or allied health staff or facilities given the treatment or clinical care proposed;
    d. Accreditation does not of itself constitute an employment contract nor does it establish a service contract between the Accredited Practitioner and Nexus Hospitals or the Facility;
    e. It is a condition of accepting accreditation, and of ongoing accreditation, that the Accredited Practitioner understands and agrees that these By-Laws are the full extent of processes and procedures available to the Accredited Practitioner with respect to all matters relating to and impacting upon accreditation, and no additional procedural fairness or natural justice principles will be incorporated or implied, other than processes and procedures that have been explicitly set out in these By-Laws;
    f. Accredited Practitioners acknowledge and agree as a condition of the granting of, and ongoing accreditation, that:
        i. the granting of accreditation establishes only that the Accredited Practitioner is a person eligible to provide services at the Facility, and failure to comply with the By-Laws at any time thereafter may result in the revocation of that accreditation;
        ii. the granting of accreditation creates no rights or legitimate expectation with respect to access to the Facility or its resources; and
        iii. while representatives of Nexus and the Facility will generally conduct themselves in accordance with these By-Laws, they are not legally bound to do so and there are no legal consequences for Nexus or the Facility and its representatives in not doing so.
    g. Holding Accreditation does not give the Accredited Practitioner any right, entitlement, guarantee or legitimate expectation in relation to:
        i. Any level of availability of theatre / procedural room access;
        ii. Any allocation of operation / procedural session time; or
        iii. The admission of any patient.

Accredited Practitioners must be Accredited to admit or treat patients

27. An Accredited Practitioner may only apply to the GM/DON to admit and treat patients at Nexus Hospitals within their approved Scope of Clinical Practice and in accordance with services the particular Facility is licenced to undertake.
28. Credentialing is limited to:
    a. The Facility or Facilities named in the accreditation notification; and
    b. The Scope of Clinical Practice identified in the accreditation notification with respect to the particular Facility or Facilities.

Application for accreditation:

29. An applicant for credentialing with respect to a facility owned or operated by Nexus must utilise the process in place for submissions of applications, which may be an electronic submission.
30. The application must:
    a. Specify the Scope of Clinical Practice applied for;
    b. Be accurate, not misleading, contain all relevant information, be fully completed and include every document specified;
    c. Nominate the Nexus Hospital location/s applied for; and
    d. Meet all requirements in place for credentialing from time to time, which may be incorporated into a Credentialing policy. The Credentialing policy may include (but not be limited to) requirements for identification, working with children checks, police checks, information regarding vaccination status, and requirements for certain clinical areas or sub-specialities such as paediatrics.

Compliance with By-Laws:

31. Every applicant for accreditation must acknowledge that the information submitted is true and correct and that he or she will comply with and be bound by these By-Laws as a continuing condition of accreditation.

Process on receipt of application for accreditation:

32. On first receiving an application for accreditation, the GM/DON may choose to reject the application at their sole discretion without assigning a reason for this decision, however the applicant must be notified in writing that the application has not been successful.
33. By-Law 32 may not be used by the GM/DON to reject an application for re-accreditation, other than if the application is not fully completed and/or does not supply all required documentation.
34. If the GM/DON:
    a. Does not reject the application for Accreditation on first receiving it; and
    b. Considers the application is likely to meet the requirements of these By-Laws, the GM/DON will forward the application to the Credentialing Committee, or Medical Advisory Committee where a separate Credentialing Committee has not been established, for review and recommendation.

Credentialing Committee

35. The function of considering applications for accreditation and re-accreditation, and of formulating recommendations to the GM/DON regarding accreditation, re-accreditation and Scope of Clinical Practice, must be performed by the Credentialing Committee, if such a committee has been established separate to the Medical Advisory Committee. If the members of the Medical Advisory Committee perform the role of the Credentialing Committee, then the meeting minutes will formally record the opening and closing of the Medical Advisory Committee and Credentialing Committee as separate meetings.

36. Where established, the Credentialing Committee must be a sub-committee of the MAC that has been convened for that purpose.
37. Where voting on an issue is performed pursuant to these By-Laws, the vote of a simple majority of those present (including by electronic means) will determine the issue.
38. Unless otherwise provided within these By-Laws, if an equality of votes occurs, the Chairperson of the Credentialing Committee (or Medical Advisory Committee as appropriate) shall have a casting vote in relation to the recommendation.

Process of the Credentialing Committee

39. The Credentialing Committee (or Medical Advisory Committee) will make a recommendation to the GM/DON whether to accept or decline the application for accreditation, and to make a recommendation regarding the Scope of Clinical Practice and any special conditions that should apply to the applicant.
40. The Credentialing Committee may choose to invite oral submissions from the applicant when considering an application for credentialing.
41. To assist in the Credentialing Committee's deliberations and peer review the Credentialing Committee may:
    a. Co-opt other Accredited Practitioners at the Facility where the Credentialing Committee performs its functions or that are suitably experienced, qualified and independent; and/or
    b. seek advice from a nominee of the relevant specialist College or professional body who is independent and has no conflict of interest with the applicant, prior to making a recommendation to the GM/DON.
42. Members of the Credentialing Committee must declare and, where necessary, refrain from participation in the deliberations where a conflict of interest exists.
43. In considering an application for accreditation, the Credentialing Committee's consideration will include the following:
    a. The credentials, competence and current fitness of the applicant;
    b. Any requirements set out in a Credentialing policy (if any) in place at the Facility;
    c. Whether, and to what extent, the qualifications, experience, skills and training of the applicant support the application and proposed Scope of Clinical Practice;
    d. The character and standing of the applicant; whether the applicant is a suitable person to practise at the Facility, and any matters relating to their behaviour, conduct and reputation;
    e. Whether the Facility has the facilities and resources to support the Scope of Clinical Practice proposed by the applicant in accordance with considerations of organisational capability and organisational need of the Facility;
    f. Clinical performance of the applicant, including patient outcomes, adverse events, complaints, participation in internal and external audits and quality assurance activities as well as continuing professional development programmes of respective Colleges and professional bodies;
    g. Removal or restriction of credentialling privileges at other health facilities;
    h. AHPRA and other regulatory notifications, investigations, restrictions, undertakings and outcomes; and
    i. Previous non-compliance with or actions taken pursuant to these By-Laws.

Decision by GM DON

44. Where the GM/DON has referred an application for accreditation to the Credentialing Committee, the GM/DON must take into account (but is not bound by) any recommendation made by the Credentialing Committee before making a decision on the application.

45. In addition to consideration of the recommendation made by the Credentialing Committee, including credentials, competence, current fitness, organisational capability and organisational need, the GM/DON may consider any other matter assessed as relevant to making the decision.
46. The GM/DON may decide to reject, accept or accept in part the recommendation by the Credentialing Committee regarding the application for accreditation or re-accreditation.
47. The GM/DON must notify the applicant of the outcome and, if accepted in whole or in part, the notification must set out the particulars of that accreditation, including;
    a. Agreed Scope of Clinical Practice;
    b. Conditions that will apply to the accreditation;
    c. The term of the accreditation; and
    d. The facility or facilities where the applicant will hold accreditation.
48. For a first time application for accreditation, the GM/DON is not required to provide any reasoning for the decision on the application as no appeal is available from that decision pursuant to these By-Laws. However, for a re-accreditation application that results in a rejection of the application in whole or in part, the GM/DON will provide sufficient reasons to assist in any appeal that may be made in accordance with these By-Laws.
49. There is no right of appeal from a decision to reject an application for accreditation, or any terms or conditions that may be attached to the approval of an application for accreditation.

Term of accreditation

50. The term of accreditation or re-accreditation will be for a period up to, but no more than, 5 years. In states/jurisdictions where the period is mandated as 3 years, this will be modified to reflect that. There is the ability to accredit for a shorter period of time initially for various reasons such as training programs or visa restrictions or the nature of services.

Temporary accreditation

51. Subject to compliance with application processes of these By-Laws for temporary accreditation, the GM/DON may authorise a medical practitioner, dentist or other health practitioner to treat patients at the Facility before the application has been finally determined or for other reasons as determined appropriate.
52. Temporary accreditation enables a medical practitioner, dentist or other health practitioner to treat patients at the specified Facility until one of the following occurs, as specified by the GM/DON in the written approval of temporary accreditation:
    a. A recommendation relating to the application for accreditation of the practitioner has been made by the Credentialling Committee;
    b. A specified date; or
    c. Conclusion of an episode of care relating to a specific patient.
53. The maximum period of temporary accreditation that can be authorised is six months, other than in exceptional circumstances as approved by the GM/DON. In states and territories where the period is mandated to 90 days, this is to be complied with.
54. The granting of temporary accreditation must be reported to the next meeting of the Credentialing Committee and be documented in the committee minutes.
55. A medical practitioner, dentist or other health practitioner who treats his or her patients at a facility where he or she has been given temporary accreditation must comply with the terms of that temporary accreditation and these By-Laws.

56. There can be no expectation that a grant of temporary accreditation will lead to subsequent granting of accreditation.
57. There are no rights of appeal from decisions relating to the granting of or terminating temporary accreditation.

Re-accreditation

58. An Accredited Practitioner must apply for a renewal of their Accreditation 90 days prior to the end of their accreditation period, or such later period as may be approved by the GM/DON. This is to be completed using the required process.
59. The administrative processes for re-accreditation must be the same as for an initial application for accreditation, other than where these requirements have been waived by the GM/DON in compliance with By-Law 60, and must otherwise be in compliance with the credentialing and accreditation processes and requirements set out in these By-Laws.
60. The GM/DON, after consultation with the Chairperson of the MAC, may waive any requirements with respect to an application for re-accreditation if those requirements appear unnecessary in the circumstances, however a formal consideration of the application and approval of Scope of Clinical Practice must still occur.

Lapse or conclusion of accreditation

61. Where an Accredited Practitioner does not seek re-accreditation prior to the expiration of the term of accreditation, the accreditation will lapse on the last day of the period for which he or she has been accredited. Notification confirming the lapse will be sent by the Credentialing Officer of the Facility to the Accredited Practitioner.
62. If an Accredited Practitioner fails to adhere to the clinical services capability framework applicable to the relevant hospital, fails to meet any specified minimum admission or utilisation expectations or fails to properly utilise allocated operating theatre time on a consistent basis, the GM/DON, in consultation with the Chairperson of MAC, and in the absence of what is considered by the GM/DON to be a satisfactory explanation, may give notice to the Accredited Practitioner that accreditation is revoked. There is no appeal available pursuant to these By-Laws from such a decision of the GM/DON.

Locum tenens

63. Locums must be approved by the GM/DON before they are permitted to arrange the admission of and/or to treat patients on behalf of an Accredited Practitioner.
64. Temporary accreditation requirements must be met before approval of locums is granted.
65. There is no appeal available from decisions relating to locum appointments.

Section 4

RESIGNATIONS VARIATIONS SUSPENSION OR TERMINATION OF ACCREDITATION

RESIGNATION, VARIATION, REVIEW, SUSPENSION OR TERMINATION OF ACCREDITATION

Resignation or extended absence of an Accredited Practitioner

66. An Accredited Practitioner who intends to cease treating patients either indefinitely or for an extended period at a Facility that he or she is accredited should notify that intention to the GM/DON in writing. Accreditation will conclude on the date that the resignation becomes effective, which in the ordinary course will be the agreed date between the Accredited Practitioner and GM/DON.

Accredited Practitioners may request variation of accreditation

67. An Accredited Practitioner may request a variation to his or her accreditation at any time and the process to follow will be the same process as an application for accreditation.

Review of accreditation or Scope of Clinical Practice

68. The GM/DON or the Nexus CMO may at any time initiate a review of an Accredited Practitioner's accreditation or Scope of Clinical Practice on such grounds as the GM/DON or the Nexus CMO think fit, including without limitation where concerns or an allegation are identified or raised about the Accredited Practitioner in relation to any of the following:
    a. There is a risk to the health, safety or welfare of any person in connection with the Facility;
    b. The rights or interests of a patient, staff, contractor or any other person in connection with the Facility has been adversely affected or could be infringed upon;
    c. Non-compliance with the Behavioural Standards;
    d. The Accredited Practitioner's competence;
    e. The Accredited Practitioner's current fitness;
    f. The Accredited Practitioners performance;
    g. The Accredited Practitioner's continuing accreditation is not consistent with organisational capability or organisational need of the Facility;
    h. The current Scope of Clinical Practice granted does not support the care or treatment sought to be undertaken by the Accredited Practitioner;
    i. Loss of confidence in the Accredited Practitioner;
    j. Failure to comply with these By-Laws;
    k. The efficient operation of the Facility could be threatened or disrupted;
    l. potential non-compliance with or loss of the Facility's licence or accreditation;
    m. the potential to bring Nexus or the Facility into disrepute;
    n. A breach of a legislative or legal obligation of the Facility or imposed upon the Accredited Practitioner may have occurred; or
    o. Circumstances elsewhere defined in these By-Laws.
69. The GM/DON and/or Nexus CMO, will determine whether the process to be followed is an:
    a. Internal Review; or
    b. External Review.
70. Prior to determining whether an Internal Review or External Review will be conducted, the GM/DON and/or Nexus CMO may at their discretion meet with the Accredited Practitioner, along with any other persons they consider appropriate, to advise them of the concern or allegation raised, and invite them to provide a preliminary response from the Accredited Practitioner (in writing or orally as determined by the GM/DON) before the GM/DON or CMO makes a determination whether a review will proceed, and if so, the type of review.

71. The review may have wider terms of reference than a review of the Accredited Practitioner's accreditation or Scope of Clinical Practice.
72. The GM/DON or CMO will then make a determination whether to impose an interim suspension or conditions upon the accreditation of the Accredited Practitioner pending the outcome of the review and, if imposed, there is no right of appeal from this interim decision pursuant to these By-Laws. In addition or as an alternative to conducting an internal or external review, the GM/DON will notify the Accredited Practitioner's registration board and/or other professional body responsible for the Accredited Practitioner of details of the concerns raised where such disclosure is required by legislation, where it is considered to be in the interests of patient care or safety to do so, where it is in the interests of protection of the public (including patients at other facilities) to do so, or where it is considered that the registration board or professional body is more appropriate to investigate and take necessary action. Following the outcome of any action taken by the registration board and/or other professional body, the GM/DON and/or Nexus CMO may also elect to take action, or further action, under these By-Laws.

Internal Review

73. The GM/DON and/or Nexus CMO will establish the terms of reference of the Internal Review, and will co-ordinate with the Medical Advisory Committee or co-opted Accredited Practitioners or personnel from within the Facility who bring specific expertise to the Internal Review as determined appropriate.
74. The terms of reference, process, and reviewers will be as determined by the GM/DON, and will ordinarily include the opportunity for submissions from the Accredited Practitioner, which may be written and/or oral.
75. The GM/DON or CMO will notify the Accredited Practitioner in writing of the review, the terms of reference, process and reviewers.
76. A report on the findings of the review in accordance with the terms of reference will be provided by the reviewers to the CEO. Following consideration of the report, the CEO is required to make a determination of whether or not to continue accreditation (including with conditions), or otherwise amend, suspend or terminate an Accredited Practitioner's Accreditation in accordance with these By-laws.
77. The CEO (or GM/DON or CMO as delegate) must notify the Accredited Practitioner in writing of the determination made in relation to the accreditation, the reasons for it, and advise of the right of appeal, the appeal process and the timeframe for an appeal.
78. The Accredited Practitioner shall have the rights of appeal established by these By-Laws in relation to the final determination made by the CEO, if a decision is made to amend, suspend, terminate or impose conditions on the Accredited Practitioner's accreditation.
79. In addition to, or as an alternative to taking action in relation to the report of the findings of the Internal Review, the GM/DON or Nexus CMO will notify the Accredited Practitioner's registration board and/or other professional body responsible for the Accredited Practitioner of details of the concerns raised and outcome of the review if required by legislation. Otherwise, the GM/DON or Nexus CMO may make such notification if it considers it is in the interests of patient care or safety to do so, it is in the interests of protection of the public to do so, it is considered appropriate that the registration board or professional body consider the matter, or it should be done to protect the interests of the Facility.

External Review

80. The GM/DON and/or Nexus CMO will make a determination about whether an External Review will be undertaken.

81. An External Review will be undertaken by a person(s) external to the Facility and of the Accredited Practitioner in question and such person(s) will be nominated by the GM/DON and/or Nexus CMO at their sole discretion.
82. The terms of reference, process, and reviewers will be as determined by the GM/DON and/or Nexus CMO. The process will ordinarily include the opportunity for submissions from the Accredited Practitioner, which may be written and/or oral.
83. The GM/DON or CMO will notify the Accredited Practitioner in writing of the review, the terms of reference, process and reviewer.
84. The reviewer is required to provide a report to the CEO on the findings of its review in accordance with the terms of reference of the review.
85. The CEO will consider the report from the reviewer and make a determination as to whether to continue (including with conditions), amend, suspend or terminate the Accredited Practitioner's accreditation or Scope of Clinical Practice in accordance with these By-laws.
86. The CEO (or GM/DON or CMO as delegate) must notify the Accredited Practitioner in writing of the determination made in relation to the accreditation, the reasons for it, and advise of the right of appeal, the appeal process and the timeframe for an appeal.
87. The Accredited Practitioner shall have the rights of appeal established by these By-Laws in relation to the final determination made by the CEO if a decision is made to amend, suspend, terminate or impose conditions on the Accredited Practitioner's accreditation.
88. In addition or as an alternative to taking action in relation to the accreditation following receipt of the reviewer's report, the GM/DON or Nexus CMO will notify the Accredited Practitioner's registration board and/or other professional body responsible for the Accredited Practitioner of details of the concerns raised and outcome of the review if required by legislation. Otherwise, the GM/DON or Nexus CMO may make such notification if it considers it is in the interests of patient care or safety to do so, it is in the interests of protection of the public to do so, it is considered appropriate that the registration board or professional body consider the matter, or it should be done to protect the interests of the Facility.

Suspension of Accreditation

89. The CEO (or GM/DON or Nexus CMO as delegate) may immediately suspend an Accredited Practitioner's accreditation if they consider:
    a. that it is in the interests of patient care or safety to do so;
    b. the continuance of the current Scope of Clinical Practice raises a significant concern about the safety and/or quality of health care to be provided by the Accredited Practitioner;
    c. it is in the interests of staff welfare or safety to do so;
    d. serious and unresolved allegations have been made in relation to the Accredited Practitioner;
    e. The Accredited Practitioner fails to observe the terms and conditions of his/her accreditation;
    f. The behaviour or conduct of the Accredited Practitioner is in breach of a direction or an undertaking, or the Facility By-Laws, policies and/or procedures;
    g. the behaviour or conduct of the Accredited Practitioner is such that it is unduly hindering the efficient operation of the Facility at any time, is bringing Nexus or the Facility into disrepute, does not comply with the Behavioural Standards, or is considered disruptive or a Behavioural Sentinel Event;
    h. the Accredited Practitioner has been suspended by their registration board;

i. there is a finding of professional misconduct, unprofessional conduct, unsatisfactory professional conduct or some other adverse professional finding (however described) by a registration board or other relevant disciplinary body or professional standards organisation for the Accredited Practitioner;
j. the Accredited Practitioner's professional registration is amended, or conditions imposed, or undertakings agreed, irrespective of whether this relates to a current or former patient of the Facility;
k. the Accredited Practitioner has made a false declaration or provided false or inaccurate information to Nexus or the Facility, either through omission of important information or inclusion of false or inaccurate information;
l. the Accredited Practitioner fails to make the required notifications or continuous disclosure required to be given pursuant to these By-Laws or based upon the information contained in a notification or continuous disclosure suspension is considered appropriate;
m. the Accreditation, clinical privileges or Scope of Clinical Practice of the Accredited Practitioner has been suspended, terminated, restricted or made conditional by another health care organisation;
n. based upon a finalised Internal Review or External Review pursuant to these By-Laws any of the criteria for suspension are considered to apply;
o. an Internal Review or External Review has been initiated pursuant to these By-laws and the CEO (or GM/DON or Nexus CMO as delegates) considers that an interim suspension is appropriate pending the outcome of the review;
p. the Accredited Practitioner has been convicted of a crime which could affect his or her ability to exercise his or her Scope of Practice safely and competently and with the confidence of the Facility and the broader community;
q. There are other unresolved issues in respect of the Accredited Practitioner such that the CEO, (or GM/DON or Nexus CMO as delegates) considers that the continuing accreditation of the Accredited Practitioner would not be in the interests of the Facility or Nexus Hospitals.

90. The CEO (or GM/DON or Nexus CMO as delegates) shall notify the Accredited Practitioner in writing of:
    a. the fact of the suspension;
    b. the period of suspension;
    c. the reasons for the suspension;
    d. If the Board considers it applicable and appropriate in the circumstances, invite a written response from the Accredited Practitioner, including a response why the Accredited Practitioner may consider the suspension should be lifted;
    e. if the CEO (or GM/DON or Nexus CMO as delegates) consider it applicable and appropriate in the circumstances, any actions that must be performed for the suspension to be lifted and the period within which those actions must be completed; and
    f. The right of appeal (if any), the appeal process and the timeframe for an appeal.
91. As an alternative to an immediate suspension, the CEO (or GM/DON or CMO as delegate) may elect to deliver a show cause notice to the Accredited Practitioner advising of:
    a. the facts and circumstances forming the basis for possible suspension;
    b. the grounds under the By-Laws upon which suspension may occur;
    c. invite a written response from the Accredited Practitioner, including a response why the Accredited Practitioner may consider suspension is not appropriate;
    d. if applicable and appropriate in the circumstances, any actions that must be performed for the suspension not to occur and the period within which those actions must be completed; and

e. a timeframe in which a response is required from the Accredited Practitioner to the show cause notice.

92. Following receipt of the response to the show cause notice in the preceding By-Law, the CEO will determine whether the accreditation will be suspended. If suspension is to occur, notification will be sent in accordance with this By-Law.
93. The suspension is ended either by terminating the accreditation or lifting the suspension. This will occur by written notification by CEO (or GM/DON or Nexus CMO as delegates).
94. The affected Accredited Practitioner may appeal the decision in accordance with these By-Laws.
95. If there is held, in good faith, a belief that the matters forming the grounds for suspension give rise to a significant concern about the safety and quality of health care provided by the Accredited Practitioner including but not limited to patients outside of the Facility, it is in the interests of patient care or safety to do so, it is in the interests of protection of the public (including patients at other facilities) to do so, it is required by legislation, or for other reasonable grounds, the GM/DON or Nexus CMO will notify the Accredited Practitioner's registration board and/or other relevant regulatory agency of the suspension and the reasons for it.
96. Accredited Practitioners accept and agree that, as part of the acceptance of accreditation, a suspension of accreditation carried out in accordance with these By-Laws is a safety and protective process rather than a punitive process, and as such it does not result in an entitlement to any compensation, including for economic loss or reputational damage.

Termination of accreditation

97. Accreditation shall be immediately terminated by the CEO if the following has occurred, or if it appears based upon the information available that the following has occurred:
    a. the Accredited Practitioner ceases to be registered with their relevant registration board;
    b. The Accredited Practitioner ceases to maintain adequate professional indemnity insurance covering their Scope of Clinical Practice;
    c. there is a finding of professional misconduct, unprofessional conduct, unsatisfactory professional conduct or some other adverse professional finding (however described) by a registration board or other relevant disciplinary body or professional standards organisation for the Accredited Practitioner;
    d. a term or condition that attaches to an approval of accreditation is breached, not satisfied, or according to that term or condition results in the accreditation concluding;
    e. it is in the interests of staff welfare or safety to do so;
    f. a contract of employment or a contract to provide services to the Facility is terminated or ends, and is not renewed;
    g. based upon a finalised Internal Review or External Review pursuant to these By-Laws and termination of accreditation is considered appropriate in circumstances where the CEO does not have confidence in the continued appointment of the Accredited Practitioner;
    h. the Accredited Practitioner is not regarded by the CEO as having the appropriate current fitness to retain accreditation or their Scope of Clinical Practice;
    i. conditions have been imposed by the Accredited Practitioner’s registration board and the GM/DON of the relevant Facility elects not to accommodate the conditions imposed;

j. the Accredited Practitioner has not exercised accreditation or utilised the facilities at the Facility for a continuous period of 12 months, or at a level or frequency as otherwise specified to the Accredited Practitioner by the GM/DON;
k. their Scope of Clinical Practice is no longer supported by the workforce capability or operational need of the Facility;
l. the Accredited Practitioner becomes permanently incapable of performing his/her duties which shall for the purposes of these By-Laws be a continuous period of six months' incapacity; or
m. there are other unresolved issues or other concerns in respect of the Accredited Practitioner such that the CEO (or GM/DON or Nexus CMO as delegates) considers that the continuing accreditation of the Accredited Practitioner would not be in the interests of the Facility or Nexus Hospitals.

98. Where termination of Accreditation does occur, the CEO (or GM/DON or CMO as delegate) shall notify the Accredited Practitioner of:
    a. the fact of the termination;
    b. the reasons for the termination;
    c. if the CEO considers it applicable and appropriate in the circumstances, it may invite a written response from the Accredited Practitioner as to why a termination of accreditation should not be imposed; and
    d. if a right of appeal is available in the circumstances, the right of appeal, the appeal process and the time frame for an appeal.
99. As an alternative to an immediate termination, the CEO may elect to deliver a show cause notice to the Accredited Practitioner advising of:
    a. the facts and circumstances forming the basis for possible termination;
    b. the grounds under the By-Laws upon which termination may occur;
    c. if applicable and appropriate in the circumstances, any actions that must be performed for the termination not to occur and the period within which those actions must be completed; and
    d. a timeframe in which a written response is required from the Accredited Practitioner to the show cause notice.
100. Following receipt of the response the CEO will determine whether the accreditation will be terminated. If termination is to occur notification will be sent in accordance with these By-Laws. Otherwise the Accredited Practitioner will be advised that termination will not occur, however this will not prevent the CEO from taking other action at this time, including imposition of conditions on their accreditation, nor from relying upon these matters as a ground for suspension or termination in the future.
101. All terminations must be notified to the MAC.
102. For a termination of accreditation pursuant to By-Law 97 (a) to (c), there shall be no ability to appeal.
103. Unless it is determined not appropriate in the particular circumstances, the fact and details of the termination will be notified by the CEO (or GM/DON or Nexus CMO as delegates) to the Accredited Practitioner's registration board and/or other relevant regulatory agencies.
104. Accredited Practitioners accept and agree, as part of the acceptance of accreditation, that a termination of accreditation carried out in accordance with these By-Laws is a safety and protective process rather than a punitive process, and as such it does not result in an entitlement to any compensation, including for economic loss or reputational damage.

Imposition of conditions

105. At the conclusion of or pending finalisation of a review, or in lieu of a suspension or in lieu of a termination of accreditation, the CEO in consultation with the Nexus CMO may elect to impose conditions on the accreditation or Scope of Clinical Practice of the Accredited Practitioner.
106. The CEO (or GM/DON or CMO as delegate) must notify the Accredited Practitioner in writing of the imposition of conditions, the consequences if the conditions are breached, and advise of the right of appeal, the appeal process and the timeframe for an appeal.
107. If the CEO considers it applicable and appropriate in the circumstances, they may also invite a written response from the Accredited Practitioner as to why the Accredited Practitioner may consider the conditions should not be imposed.
108. If the conditions are breached, then suspension or termination of accreditation may occur, as determined by the CEO.
109. The affected Accredited Practitioner shall have the rights of appeal established by these By-Laws.
110. If there is held, in good faith, a belief that the continuation of the unconditional right to practise in any other organisation would raise a significant concern about the safety and quality of health care for patients and the public, the CEO (or GM/DON or Nexus CMO as delegates) will notify the Accredited Practitioner's registration board and/or other relevant regulatory agency of the imposition of the conditions and the reasons the conditions were imposed.
111. Accredited Practitioners accept and agree, as part of the acceptance of Accreditation, that an imposition of conditions carried out in accordance with these By-Laws is a safety and protective process rather than a punitive process, and as such it does not result in an entitlement to any compensation, including for economic loss or reputational damage.

Effect of suspension or termination of accreditation at other Nexus Facilities

112. If the GM/DON or Nexus CMO suspends an Accredited Practitioner’s Accreditation in respect of a Facility, unless determined otherwise by the CEO, the suspension will simultaneously be imposed across all Nexus Facilities to which the Accredited Practitioner holds accreditation and any conditions imposed will apply across all Nexus Facilities.
113. If the CEO terminates an Accredited Practitioner’s Accreditation in respect to a Nexus Facility, unless determined otherwise by the CEO, the termination will simultaneously apply to all other Nexus Facilities where the Accredited Practitioner holds accreditation.

Section 5

APPEALS

APPEALS

No right of appeal unless specifically conferred

114. An Accredited Practitioner has no ability to appeal a decision to suspend, vary or terminate::
    a. Any decision made in accordance with these By-Laws; or
    b. Any decision purportedly made in accordance with these By-Laws;

    unless these By-Laws expressly give the Accredited Practitioner the ability to appeal that decision.
115. An Accredited Practitioner has no ability to appeal the exercise of any discretion conferred by these By-laws.
116. There shall be no appeal against a decision to not approve initial or first time accreditation, temporary accreditation or locum accreditation.
117. Unless decided otherwise by the CEO in the circumstances of the particular case, which will only be in exceptional circumstances, lodgement of an appeal does not result in a stay of the decision under appeal and the decision will stand and be actioned accordingly.

Right to appeal the decision of the CEO

118. If an Accredited Practitioner wishes to appeal a decision in respect of which these By-Laws give a right of appeal, the Accredited Practitioner must lodge an appeal in writing with the CEO within 14 days of being notified of the decision.
119. It is sufficient to lodge an appeal in writing for the Accredited Practitioner to:
    a. State that he or she appeals a decision in respect to which these By-Laws give the ability to appeal; and
    b. Specify the reason for the appeal.

Procedure for appeal

120. Upon receipt of an appeal notice the GM/DON will immediately forward the appeal request to the CEO.
121. The CEO will nominate an Appeal Committee to hear the appeal, establish terms of reference, and submit all relevant material to the Chairperson of the Appeal Committee.
122. The Appeal Committee shall comprise at least three (3) persons and will include:
    a. a nominee of the CEO, who may be an Accredited Practitioner, who must be independent of the decision under appeal regarding the Accredited Practitioner, and who will be the Chairperson of the Appeal Committee;
    b. a nominee of the CMO, who may be an Accredited Practitioner, and who must be independent of the decision under appeal regarding the Accredited Practitioner;
    c. any other member or members who bring specific expertise to the decision under appeal, as determined by the CEO, who must be independent of the decision under appeal regarding the Accredited Practitioner, and who may be an Accredited Practitioner. The CEO at their complete discretion may invite the appellant to make suggestions or comments on the proposed additional members of the Appeal Committee (other than the nominees in (a) and (b) above), but is not bound to follow the suggestions or comments;
123. Before accepting the appointment, the nominees will confirm that they do not have a known conflict of interest with the appellant and will sign a confidentiality agreement. Once all members of the Appeal Committee have accepted the appointment, the CEO will notify the appellant of the members of the Appeal Committee.

124. Unless a shorter timeframe is agreed by the appellant and the Appeal Committee, the appellant shall be provided with at least 14 days' notice of the date for determination of the appeal by the Appeal Committee. The notice from the Appeal Committee will ordinarily set out the date for determination of the appeal, the members of the Appeal Committee, the process that will be adopted, and will invite the appellant to make a submission about the decision under appeal. Subject to an agreement to confidentiality from the appellant, the Chairperson of the Appeal Committee may provide the appellant with copies of material to be relied upon by the Appeal Committee.
125. The appellant will be given the opportunity to make a submission to the Appeal Committee. The Appeal Committee shall determine whether the submission by the appellant may be in writing or in person or both.
126. If the appellant elects to provide written submissions to the Appeal Committee, following such a request from the Appeal Committee for a written submission, unless a longer time frame is agreed between the appellant and Appeal Committee the written submission will be provided within 7 days of the request.
127. The CEO (or nominee) may present to the Appeals Committee in order to provide relevant information in relation to the decision under appeal.
128. If the appellant attends before the Appeal Committee to answer questions and to make submissions, the appellant is not entitled to have formal legal representation at the meeting of the Appeal Committee. The appellant is entitled to be accompanied by a support person, who may be a lawyer, but that support person is not entitled to address the Appeal Committee.
129. The appellant shall not be present during Appeal Committee deliberations except when invited to be heard in respect of his/her appeal.
130. The Chairperson of the Appeal Committee shall determine any question of procedure for the Appeal Committee, with questions of procedure entirely within the discretion of the Chairperson of the Appeal Committee.
131. The Appeal Committee will make a written recommendation regarding the appeal to the CEO, including provision of reasons for the recommendation. The recommendation may be made by a majority of the members of the Appeal Committee and if an even number of Appeal Committee members then the Chairperson has the deciding vote. A copy of the recommendation will be provided to the appellant.
132. The CEO will consider the recommendation of the Appeal Committee and make a decision about the appeal.
133. The decision of the CEO will be notified in writing to the appellant.
134. The decision of the CEO is final and binding, and there is no further appeal allowed under these By-Laws from this decision.
135. If a notification has already been given to an external agency, such as a registration board, then the Board will notify that external agency of the appeal decision. If a notification has not already been given, the Board will make a determination whether notification should now occur based upon the relevant considerations for notification to an external agency as set out in these By-Laws relating to the decision under appeal.

Section 6

GENERAL CONDITIONS OF ACCREDITATION

GENERAL CONDITIONS OF ACCREDITATION

Accreditation is personal

136. The Accreditation of an Accredited Practitioner is personal and cannot be transferred to, or be exercised by, any other person.

Accreditation permits a delineated Scope of Clinical Practice

137. An Accredited Practitioner must admit and treat patients only within the delineated Scope of Clinical Practice in his or her accreditation notification, must comply with ‘General Conditions’ set out in these By-Laws and any ‘Special Conditions’ noted in the approval of accreditation. To the extent of any inconsistency between the General Conditions and the Special Conditions, the Special Conditions prevail.

Compliance with Laws, Policies and Professional Standards

138. An Accredited Practitioner must comply with:
    a. These By-Laws;
    b. All applicable laws concerning the provision of health care services to patients at private hospitals;
    c. The policies, rules and procedures of Nexus and the specific Facility at which they are Accredited;
    d. Any vaccination requirements in place and applicable in the relevant State or Territory, or accrediting body, as well as any Nexus vaccination policy in place at the relevant Facility;
    e. Accepted professional and ethical standards and relevant codes of conduct; and
    f. National and State or Territory standards and legislative requirements.

Representation and media

139. Unless an Accredited Practitioner has the prior written consent of the CEO, an Accredited Practitioner may not use Nexus’s or the Facility's name, letterhead, logo, or in any way suggest that the Accredited Practitioner represents these entities.
140. The Accredited Practitioner must obtain the CEO’s prior written approval before interaction with the media regarding any matter involving Nexus, the Facility or a patient.

Professional indemnity insurance and professional registration

141. An Accredited Practitioner must maintain and hold at all times adequate professional indemnity insurance.
142. The professional indemnity insurance must indemnify the Practitioner for the entirety of his or her Scope of Clinical Practice.
143. Unless exempted by the CEO, such insurance must have no exclusions or deductibles relevant to the Accredited Practitioner’s Scope of Clinical Practice.
144. The limits of indemnity of the policy must be adequate in the opinion of the GM/DON.
145. An Accredited Practitioner must, if requested by the GM/DON, provide an authority directed to the Accredited Practitioner’s professional indemnity insurer to provide to the GM/DON evidence of the terms of that practitioner’s insurance, including the limits and currency of that insurance.
146. An Accredited Practitioner must at all times maintain registration with AHPRA that is sufficient for the Scope of Clinical Practice granted.

Quality Assurance

147. An Accredited Practitioner must:
    a. Participate in Continuing Professional Development programmes concerning his or her discipline or specialty, and provide evidence to the GM/DON of this participation;
    b. Participate in quality assurance (including clinical audit, clinical variation review and peer review) programmes of the Facility;
    c. Participate in the review of clinical performance indicators and other measures of clinical care;
    d. Participate in all audit, educational and continuing professional development activities as required by the clinical College or Professional Body awarding the qualifications upon which the Accredited Practitioner's accreditation is based;
    e. Assist Nexus and the Facility in achieving accreditation standards as set by the Accreditation Standards, the Australian Commission on Safety and Quality in Health Care and other bodies charged with the accreditation and licensing of hospital standards.

Respect for Colleagues and Staff

148. An Accredited Practitioner must treat fairly and with respect:
    a. Other Accredited Practitioners;
    b. All staff and other people working at or engaged by the Facility or Nexus.
149. An Accredited Practitioner must not bully, harass or intimidate any person and must comply with relevant workplace legislation.

Behaviour

150. Accredited Practitioners must continuously demonstrate competence and current fitness, must not engage in disruptive behaviour, and must observe all reasonable requests with respect to conduct and behaviour.
151. Accredited Practitioners must not engage in any conduct that may be perceived as a reprisal against another person for making a report or supplying information relating to the Behavioural Standards.
152. Upon request by the GM/DON, the Accredited Practitioner is required to meet with the GM/ DON, Operations Director, Nexus CMO and/or any other persons determined appropriate by the GM/DON to discuss matters of behaviour and standard of conduct.

Standard of Conduct

153. The Facility expects a high standard of professional and personal conduct from Accredited Practitioners, who must conduct themselves in accordance with:
    a. the Behavioural Standards;
    b. the Code of Ethics of the Australian Medical Association or any other relevant code of ethics;
    c. the Code of Practice of any specialist college or professional body of which the Accredited Practitioner is a member;
    d. the limits of their registration or any conditions placed upon their Scope of Clinical Practice in accordance with these By-Laws; and
    e. all reasonable requests made with regard to personal conduct in the Facility.

Section 7

NOTIFICATIONS AND CONTINUOUS DISCLOSURE

NOTIFICATION AND CONTINUOUS DISCLOSURE REQUIREMENTS

154. Accredited Practitioners must immediately advise the GM/DON, and follow up with written confirmation within 2 days, should:
    a. an investigation or complaint be commenced in relation to the Accredited Practitioner, or about his/her patient (irrespective of whether this relates to a patient of the Facility), by AHPRA, the Accredited Practitioner's registration board, disciplinary body, Coroner, a health complaints body, or another statutory authority, State or Government agency;
    b. an adverse finding (including but not limited to criticism or adverse comment about the care or services provided by the Accredited Practitioner) be made against the Accredited Practitioner by a civil court, AHPRA, the practitioner's registration board, disciplinary body, Coroner, a health complaints body, or another statutory authority, State or Government agency, irrespective of whether this relates to a patient of the Facility;
    c. the Accredited Practitioner's professional registration be revoked or amended, or should conditions be imposed, or should undertakings be agreed, irrespective of whether this relates to a patient of the Facility and irrespective of whether this is noted on the public register or is privately agreed with a registration board;
    d. professional indemnity membership or insurance be made conditional or not be renewed, or should limitations be placed on insurance or professional indemnity coverage;
    e. the Accredited Practitioner's appointment, clinical privileges or Scope of Clinical Practice at any other facility, hospital or day procedure centre alter in any way, including through resignation, or if it is withdrawn, suspended, restricted, or made conditional, irrespective of whether this was done by way of agreement with the Accredited Practitioner;
    f. any physical or mental condition or substance abuse problem occur that could affect his or her ability to practise or that would require any special assistance to enable him or her to practice safely and competently;
    g. the Accredited Practitioner believe that patient care or safety is being compromised or at risk, or may potentially be compromised or at risk, by another Accredited Practitioner of the Facility;
    h. the Accredited Practitioner make a mandatory notification to a health practitioner registration board in relation to another Accredited Practitioner of the Facility; or
    i. the Accredited Practitioner be charged with having committed, or is convicted of, any criminal offence. The Accredited Practitioner must provide the Facility with an authority to conduct at any time a criminal history check with the authorities.

155. Accredited Practitioners must keep the GM/DON continuously informed of every fact and circumstance which has, or will likely have, a material bearing on:
   a. The Accreditation of the Accredited Practitioner;
   b. the Scope of Clinical Practice of the Accredited Practitioner;
   c. the ability of the Accredited Practitioner to safely deliver health services to his/her patients within their Scope of Clinical Practice, including if the Accredited Practitioner suffers from an illness or disability which may adversely affect his or her current fitness to practice;
   d. the Accredited Practitioner's registration or professional indemnity insurance arrangements;
   e. the inability of the Accredited Practitioner to satisfy a medical malpractice claim by a patient;
   f. adverse outcomes or complications that result in injury, disability or harm in relation to the Accredited Practitioner's patients (current or former) of the Facility;
   g. complaints, compensation claims, reportable deaths and coronial investigations in relation to the Accredited Practitioner's patients (current or former) of the Facility;
   h. the reputation of the Accredited Practitioner as it relates to the provision of clinical practice; and
   i. the reputation of Nexus or the Facility.

Section 8

SAFETY AND QUALITY

AND

CLINICAL RESPONSIBILITIES

CLINICAL RESPONSIBILITIES

Admission of patients

156. Eligibility of Accredited Practitioner's to admit and treat patients to a Facility is subject to:
    a. Procedure/operating list availability;
    b. The availability and capability of nursing or allied health staff or facilities at the hospital, relevant to the type or treatment proposed to be conducted by the Accredited Practitioner;
    c. Compliance with the clinical services capability framework (however described in the relevant State or Territory), private hospital licensing and/or American Society of Anesthesiologists (ASA) classifications applicable to that Facility; and
    d. Compliance with any Facility admission policy in place at the Facility, which may include requirements for transfer out of the Facility in the event of an emergency or the patient no longer meeting admission, clinical services capability framework, private hospital licensing or ASA classification requirements.
157. Except in an emergency, no patient will be admitted to a Facility until a valid request for admission has been provided by the Accredited Practitioner stating the reason for the admission. In the case of an emergency, at the first reasonable and appropriate opportunity, the patient will be transferred out to an appropriate acute medical facility.
158. Planned operating lists must be provided by the Accredited Practitioner prior to the booked list with sufficient prior notice as per the specified timeframe set by the Facility.

Active provider

159. The Accredited Practitioner applies for accreditation on the basis of their expectation that they will admit (if applicable) and/or treat patients at the Facility on a regular basis and be an active provider of services at the Facility.
160. Sessions for the use of operating rooms are allocated on the basis that they will be fully utilised.
161. Sessions will be allocated to the Accredited Practitioner at the complete discretion of Nexus, and past allocation of sessions does not entitle the Accredited Practitioner to right of access to future operating sessions.
162. Wherever possible, an Accredited Practitioner must give to the GM/DON adequate notice of any times during which he or she will not fully utilise any allocated operating sessions. The Facility may specify the required notice period and this will be regarded as 'adequate notice' for the purpose of this By-Law.
163. The GM/DON may:
    a. Modify or change (which includes to reduce an allocation or remove an allocation) the allocation of operating sessions having regard to utilisation or the demands for surgery; and
    b. Allow casual bookings for the whole or part of any allocated operating session which is not fully utilised.
164. An Accredited Practitioner must give the GM/DON adequate notice of his or her intention to reduce or terminate use of allocated operating sessions. The Facility may specify the required notice period and this will be regarded as 'adequate notice' for the purpose of this By-Law.

Surgery

165. Accredited Practitioners acknowledge the importance of, and will strictly adhere to, various measures aimed at ensuring safety and quality during surgery, which includes but is not limited to participating in or allowing to occur procedures relating to correct site surgery, team time out, infection control and surgical item counts. This also includes requirements relating to the use of and discard of restricted and controlled drugs.
166. Accredited Practitioners performing procedures within Facility operating suites are to be physically present within the operating suite prior to the commencement of any component of the anaesthetic.

Care of admitted patients

167. Nexus Day Hospitals supports and encourages the use of evidence-based clinical guidelines.
168. Each Accredited Practitioner is responsible for the care and treatment of his or her patients in the Facility. If the Accredited Practitioner is unable to provide that care personally, he or she must secure the agreement of another Accredited Practitioner to provide that care and treatment.
169. Accredited Practitioners who admit patients to the Facility for treatment and care must ensure that they are available to treat and care for those patients at all times, or failing that, that other arrangements as permitted by the By-Laws are put in place to ensure the continuity of treatment and care for those patients.
170. Accredited Practitioners must visit all patients admitted or required to be treated by them as frequently as is required by the clinical circumstances of those patients and as would be judged appropriate by professional peers.
171. An Accredited Practitioner must be contactable at all hours and available to review admitted patients in person or ensure their locum or on-call cover is available to review the patients in the Facility. If locum or on-call cover is not available to attend and review the patient, this must be immediately notified to the GM/DON. Persons providing on-call or covering services must be accredited at the Facility and hold the required Scope of Clinical Practice.
172. Accredited Practitioners must ensure that all reasonable requests by Facility staff are responded to in a timely manner, and in particular that patients are promptly attended to when reasonably requested by Facility staff for clinical reasons. If the Accredited Practitioner is unable to provide this level of care personally, he/she shall secure the agreement of another Accredited Practitioner to provide the care and treatment, and shall advise the staff of the Facility of this arrangement. If locum or back-up cover is not available to attend and review the patient, this must be immediately notified to the GM/DON.
173. It is the responsibility of the Accredited Practitioner to ensure any changes to contact details are notified promptly to the GM/DON. Accredited Practitioners must ensure that their communication devices are functional and that appropriate alternative arrangements are in place to contact them if their communication devices need to be turned off for any reason.
174. All locums must be approved by the GM/DON, and the Accredited Practitioner must ensure that the locum's contact details are made available to the Facility and all relevant persons are aware of the locum cover and the dates of locum cover.
175. Accredited Practitioners must only treat patients within the Scope of Clinical Practice granted.
176. Accredited Practitioners are required to work with and as part of a multi-disciplinary health care team, including effective communication both written and verbal, to ensure the best possible care for patients. Accredited Practitioners must at all times be aware of the importance of effective communication with other members of the health care team, referring doctors, the Facility executive, patients, and the patient's family or next of kin, and at all times ensure appropriate communication has occurred, adequate information has been provided, and questions or concerns have been adequately responded to.

177. Adequate instructions and clinical handover is required to be given to the Facility staff and other practitioners (including their on-call and locum cover) to enable them to understand what care the Accredited Practitioner requires to be delivered. The Accredited Practitioner must appropriately supervise the care that is provided by the Facility staff and other practitioners.
178. When an Accredited Practitioner has made an agreement to transfer responsibility for the care and treatment of his or her patient to another Accredited Practitioner, the first Accredited Practitioner must:
    a. Document the details of the transfer in the patient's medical record held by the Facility; and
    b. Communicate the transfer to the GM/DON or relevant delegate of the Facility.
179. Accredited Practitioners must recognise limitations on the patients that may be admitted to the Facility, and patients that must be transferred out of the Facility, including promptly transferring outpatients of the Facility in the event of an emergency (following immediate management of the emergency) or the patient no longer meeting admission, clinical services capability framework, private hospital licensing or ASA classification requirements.
180. Accredited Practitioners must give consideration to their own potential fatigue and that of other staff involved in the provision of patient care when making patient bookings and in utilising operating theatre and procedure room time.
181. The Accredited Practitioner must ensure that their patients are not discharged without their approval, and must comply with the discharge policy of the Facility including completing all patient discharge documents required by the Facility. It is the responsibility of the Accredited Practitioner to ensure all information reasonably necessary to ensure continuity of care after discharge is provided to the patient and their carers, the referring practitioner, general practitioner and/or other treating practitioners.

Safety Programs, initiatives and standards

182. Accredited Practitioners acknowledge the importance of ongoing safety and quality initiatives that may be instituted by Nexus or the Facility based upon its own safety and quality program, or safety and quality initiatives, programs or standards of State or Commonwealth health departments, statutory bodies or safety and quality organisations (including for example the Australian Commission on Safety and Quality in Health Care, a state-based division of a health department, or a state-based independent statutory body).
183. Accredited Practitioners will participate in and ensure compliance with these initiatives and programs (including if they are voluntary initiatives that Nexus Day Hospitals or the Facility elects to participate in or undertake), whether these apply directly to the Accredited Practitioner or are imposed upon the Facility and require assistance from the Accredited Practitioner to ensure compliance, including but not limited to the National Safety and Quality Health Service Standards and Clinical Care Standards of the Australian Commission on Safety and Quality in Health Care.

Quality improvement, risk management and regulatory agencies

184. Accredited Practitioners are required to participate in Facility clinical practice review and peer review activities, including review of their clinical data and outcomes. Accredited Practitioners are required to respond to requests for information regarding statistical outliers, adverse events and cases flagged in incidents, clinical indicator or key performance indicator reporting.
185. Accredited Practitioners are encouraged to participate in the Facility's safety, quality, risk management, education and training activities, although noting that mandatory participation may be required if mandated by a regulatory body, the GM/DON or the MAC.

186. Accredited Practitioners will report to the Facility incidents, complications or adverse events that result in injury, disability or harm, deaths and complaints relating to patients of the Accredited Practitioner in accordance with the Facility policies and procedures and where requested by the GM/DON, and will assist with incident management, investigation and reviews (including root cause analysis and other systems reviews), complaints management, and open disclosure processes.

187. Accredited Practitioners will participate in risk management activities and programs, including the implementation by the Facility of risk management strategies and recommendations from system reviews, and will maintain and comply with the ongoing minimum competency and continuing professional development requirements of their professional college with respect to their approved Scope of Clinical Practice. Where requested and, as part of accreditation applications, Accredited Practitioners will provide evidence of external education and continuing professional development.

188. Accredited Practitioners must provide all reasonable and necessary assistance in circumstances where the Facility requires assistance from the Accredited Practitioner in order to comply with or respond to a legal request or direction, including for example where that direction is pursuant to a court order, or from a health complaints body, AHPRA, Coroner, police, state health department and its agencies or departments, Private Health Unit, and Commonwealth Government and its agencies or departments.

189. Accredited Practitioners shall comply with, and take all reasonable actions to assist the Facility to comply with, each of the National Safety and Quality Health Service Standards issued by the Australian Commission on Safety and Quality in Health Care and any associated clinical guidelines.

Treatment and financial consent

190. Accredited Practitioners must obtain from the patient or their legal guardian or substituted decision maker fully informed consent for treatment (except where it is not practical in cases of emergency) in accordance with accepted medical and legal standards and in accordance with the policy and procedures of Nexus and the Facility.

191. For the purposes of this provision, an emergency exists where immediate treatment is necessary in order to save a person's life or to prevent serious injury to a person's health.

192. The consent will be evidenced in writing and signed by the Accredited Practitioner and patient or their legal guardian or substituted decision maker.

193. It is expected that fully informed consent will be obtained by the Accredited Practitioner under whom the patient is admitted or treated, in accordance with the Accredited Practitioner's non- delegable duty of care. The consent process will ordinarily include an explanation of the patient's condition and prognosis, treatment and alternatives, inform the patient of all material risks associated with treatment and alternatives, and then obtain the consent to treatment. The consent process must also satisfy Nexus or the Facility's requirements from time to time as set out in its policy and procedures.

194. Accredited Practitioners must provide full financial disclosure and obtain fully informed financial consent from their patients in accordance with the relevant legislation, health fund agreements, policy and procedures of Nexus Day Hospitals or the Facility.

Facility patient records and discharge of patients

195. An Accredited Practitioner must maintain full, accurate, contemporaneous and legible medical records for all patients treated by him or her in the patient records held by the Facility.

196. The records must include all information necessary to enable the Facility staff or other Accredited Practitioners to provide necessary care and treatment to patients.
197. The records must comply with National Standards developed by the Australian Commission on Safety and Quality in Health Care and be in the form determined appropriate by the Facility.
198. The Accredited Practitioner must document relevant Medical Benefits Scheme (MBS) item numbers and/or other information relating to the patient's treatment to allow for accurate billing of patients, health insurers or Medicare.
199. An Accredited Practitioner who admits a patient to the Facility must obtain and fully complete a 'Consent For Treatment' form from the patient or the patient's legal guardian before the patient is admitted to the hospital, with the exception of emergency cases.
200. Where an Accredited Practitioner who is admitting a patient to a Facility has not obtained a 'Consent for Treatment' form from the patient or legal guardian on or before the admission, in accordance with relevant Facility policy:
    a. Except in emergency cases, the Accredited Practitioner must obtain written informed consent before the patient receives any treatment at the hospital;
    b. Written consent must be received for patients requiring cytotoxic, biological therapy or blood product administration;
    c. Documentation of a patient's refusal of blood products must be obtained.
201. In emergency cases where possible, the signature of two Accredited Practitioners should be obtained on the 'Consent for Treatment' form attesting to the fact that, in both their opinions, the situation at hand is considered an emergency and that the patient is incapable of giving valid consent.
202. For the purposes of these By-Laws, an emergency exists in any situation where, in the opinion of the treating Accredited Practitioner, immediate treatment is necessary in order to avert a serious and imminent threat to a patient's life or physical health. In these circumstances, the immediate life-saving care will be provided and simultaneously with this appropriate transfer out to an acute medical facility will be arranged.
203. The treating Accredited Practitioner must record an appropriate patient history, physical examination and treatment plan before an operation or any potentially hazardous diagnostic procedure is undertaken. In situations where this has not occurred, the procedure must be delayed:
    a. Until the situation is clarified to the satisfaction of all persons who will be involved in the care of the patient; or
    b. Unless the Accredited Practitioner states in writing that such a delay would be detrimental to the life and recovery of the patient. In such instances post-operative/procedural completion of the medical record is mandatory.
204. Operative reports must:
    a. Include a detailed account of the findings at surgery;
    b. Include details of the surgical technique undertaken;
    c. Be written or dictated and the report signed by the attending Accredited Practitioner;
    d. Be made part of the patient's medical record; and
    e. List all relevant MBS item numbers.

205. An Accredited Practitioner who performs anaesthesia on a patient must:
    a. Obtain consent to anaesthesia;
    b. Maintain a complete anaesthetic record that includes evidence of pre-anaesthetic evaluation and post-anaesthetic follow-up of the patient's condition;
    c. Remain on the hospital site until the patient is reasonably recovered from anaesthetic; and
    d. Remain contactable via telephone until the patient's final discharge from the facility.
206. Subject to By-Laws 207 and 208:
    a. All orders (including medication) for the treatment of a patient must be:
        i. Recorded legibly in writing, noting the date and time the order is made;
        ii. Signed by the Accredited Practitioner that ordered the treatment;
        iii. If in electronic form, for example an electronic prescription, this must meet all relevant regulatory requirements; and
        iv. Compliant with all relevant state, territory or federal Health Department requirements
    b. Any order for treatment that does not comply with By-Law 206(a), must not be carried out until:
        i. The order complies with By-Law 206(a); or
        ii. The order is understood clearly by those involved in the care of the patient; and
        iii. Any regulatory requirements are met.
207. A verbal order for the treatment of a patient that is given by an Accredited Practitioner may be acted on when:
    a. It is given to a duly authorised person functioning within the scope of their clinical competence; and
    b. The order is understood clearly by those involved in the care of the patient.
208. A verbal order for the treatment of a patient that is made in accordance with By-Law 207 must be recorded in writing and signed by the Accredited Practitioner who gave the verbal order within 24 hours of making the verbal order, and if there is an electronic prescription then this must be completed in a timely way in compliance with regulatory requirements.
209. The repeated failure of an Accredited Practitioner to comply with By-Laws 207 and 208 must be brought to the attention of the GM/DON where the verbal orders were given.
210. Where a specimen is removed from a patient by an Accredited Practitioner at a procedure:
    a. The specimen must be sent to a pathologist for such examination necessary to arrive at a tissue diagnosis; and
    b. The authenticated report prepared by the pathologist must be included in the patient's medical record held by the Facility as soon as practicable after it is received.
211. An Accredited Practitioner's attendance on a patient must be documented in the patient's medical record held by the Facility, especially where:
    a. There has been a change in the patient's condition since he or she was last reviewed; or
    b. If the Accredited Practitioner initiates a change in the patient's management.
212. Pertinent progress notes must be recorded at the time of observation, sufficient to permit continuity of care, communication of clinically relevant information to nursing and other staff and transferability of the patient. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders and the results of any tests and treatments undertaken.
213. All clinical entries in a patient's medical record held by the Facility must be accurately dated, timed and authenticated.
214. All medical imaging and pathology reports must be included in a patient's medical record held by the Facility within a timeframe appropriate for the circumstances of the admission.
215. The medical record of a patient held by the Facility is the property of Nexus Day Hospitals.

216. An Accredited Practitioner must not destroy or remove or transfer from Facility premises or systems any medical record or part of a medical record or health information without the prior consent of the GM/DON.
217. Where a patient is readmitted to a Facility, that part of the medical record relating to the patient's previous admissions must be available to the Accredited Practitioner involved in the patient's treatment during the readmission.
218. An Accredited Practitioner must:
    a. Comply with the patient discharge policy of the Facility; and
    b. Complete all patient discharge documents, as relevant to the patient's care, required by the Facility.
219. A patient must be discharged only on the order of the attending Accredited Practitioner.
220. When a patient chooses to leave the Facility against the advice of the attending Accredited Practitioner:
    a. A notation must be made in the patient's medical record held by the Facility, using 'discharged against advice' documentation.
221. In the event of a patient's death within the Facility:
    a. The death must be confirmed and recorded by the attending Accredited Practitioner or their approved delegate as soon as possible; and
    b. The policies for the release of cadavers from the Facility where the patient died must comply with all relevant state and territory laws applicable to the jurisdiction of that Facility.
222. Accredited Practitioners must comply with:
    a. Nexus 'Correct Patient, Correct Procedure, Correct Site' policies;
    b. Nexus Surgical Team Time Out policies; and
    c. The Royal Australasian College of Surgeons 'Surgical Safety Checklist' policy including the requirement for Accredited Practitioners to mark the surgical site prior to the commencement of the procedure as appropriate.

Research

223. Nexus supports the conduct of research within our Facilities, including clinical trials. However, no research will be undertaken without the prior approval of the Nexus Clinical Governance Committee and a properly registered Human Research Ethics Committee (that may be external to Nexus and the Facility), following written application by the Accredited Practitioner.
224. The activities to be undertaken in the research must fall within the Scope of Clinical Practice of the Accredited Practitioner.
225. For aspects of the research falling outside an indemnity from a third party (including the exceptions listed in the indemnity), the Accredited Practitioner must have in place adequate insurance with a reputable insurer to cover the medical research.
226. Research will be conducted in accordance with National Health and Medical Research Council requirements, National Statement on Ethical Conduct in Human Research 2007 (as amended and updated from time to time), and other applicable legislation.
227. An Accredited Practitioner has no power to bind Nexus Day Hospitals to a research project (including a clinical trial) by executing a research agreement. Clinical trials must also meet the Clinical Trial Framework as part of accreditation requirements by all parties involved.
228. There is no right of appeal from a decision to reject an application for research.

New clinical services

229. Before treating patients with new clinical services, an Accredited Practitioner is required to obtain the prior written approval of the GM/DON, who will consult with and obtain a recommendation from the MAC and Nexus CMO. If approval is received it will be subject to minimum requirements of compliance with the requirements of Nexus policy (if any) for new clinical services, fall within the Accredited Practitioner's Scope of Clinical Practice or approved amendment to their Scope of Clinical Practice, and fall within the licensed service capability of the Facility.
230. The Accredited Practitioner must provide evidence of adequate professional indemnity insurance to cover the new clinical service, and if requested, evidence that private health insurers will adequately fund the new clinical services.
231. The Accredited Practitioner must provide progress reports to the GM/DON, at intervals set out in the written approval, and must comply with any subsequent directions received from the CEO, CMO or Nexus Clinical Governance Committee
232. If research is involved, then the By-Law dealing with research must be complied with.
233. A medical proctor is a Medical Practitioner not currently accredited at the Facility, who will not participate directly in the care of a patient and is present to further their own education and training through observation or is present to provide mentoring and guidance to an Accredited Practitioner, for example when the Accredited Practitioner is introducing a new clinical service. Temporary accreditation processes may, at the election of the GM/DON, be utilised for a medical proctor. The process will be modified to suit the specific circumstances and will be confined to a particular attendance rather than a period of time.
234. The GM/DON's decision is final and there shall be no right of appeal from denial of requests for new clinical services.

Surgical Assistants

235. A Medical Practitioner who is accredited at the Facility as a surgical assistant:
    a. Cannot admit a patient;
    b. Must practise under the direct supervision of the admitting Accredited Practitioner;
    c. May assist in theatre and visit a patient;
    d. May examine a patient's medical records;
    e. Cannot initiate or change a treatment order relating to a patient;
    f. May have his or her Scope of Clinical Practice limited to a particular specialty or assisting a particular surgeon; and
    g. May not:
        i. Assume or be assigned the care of a patient in place of another medical practitioner;
        ii. Prescribe medication for a patient;
        iii. Complete or witness consent for procedures.
236. The admitting Accredited Practitioner must maintain responsibility for the completion of operative records at all times.
237. Surgical assistants must practice at all times under the direct supervision of the Accredited Practitioner. The Accredited Practitioner maintains full responsibility for the surgical assistant at all times and must ensure they are properly supervised.

238. All surgical assistants must be accredited at the facility and comply with the following requirements:
    a. The surgical assistant must hold AHPRA registration that supports their Scope of Clinical Practice as an assistant;
    b. The surgical assistant must meet all requirements for accreditation including but not limited to identification checks, criminal history checks, working with children checks, immunisation requirements, continuing professional development requirements, and up-to-date hand hygiene, aseptic technique and basic life support training requirements;
    c. The surgical assistant must hold professional indemnity insurance coverage that is adequate to cover their Scope of Clinical Practice as a surgical assistant; and
    d. The surgical assistant must comply with any direction or requirement of the GM/DON, as well all the policies and procedures of the Facility.
239. Surgical assistants may be granted temporary accreditation at the Facility in accordance with By-laws 51-57.
240. The Accredited Practitioner must ensure that contemporaneous records are maintained in the Facility medical record of the patient relating to the services provided by the Assistant.

Section 9

ADDITIONAL RULES, POLICIES AND PROCEDURES, AND AUDITS

ADDITIONAL RULES, POLICIES AND PROCEDURES, AND AUDITS

Additional Rules, Policies and Procedures

241. Subject to By-Law 242, the GM/DON may develop and implement at the Facility any rules, policies or procedures the GM/DON considers necessary or desirable to improve:
    a. The quality of care provided to patients; or
    b. The safety of patients, Accredited Practitioners, other health practitioners, staff and/or all other people working at or engaged by the Facility.
242. The GM/DON must not make any rule, policy or procedure that is inconsistent with these By-Laws.

Audits and Compliance

243. The GM/DON will establish a regular audit process, at intervals determined to be appropriate by the Facility or as may be required by a regulatory authority, to ensure compliance with and improve the effectiveness of the processes set out in these By-laws relating to credentialing and accreditation, and any associated policies and procedures, including adherence by Accredited Practitioners to their approved Scope of Clinical Practice.
244. The audit process will include identification of opportunities for quality improvement in the credentialing and accreditation processes.

Section 10

CONFIDENTIALITY

CONFIDENTIALITY

General

245. Accredited Practitioners will manage all matters relating to the confidentiality of information in compliance with Nexus policy and the 'Australian Privacy Principles' established by the Privacy Act (Cth), and other legislation and regulations relating to privacy and confidentiality applicable in the relevant State or Territory, and will not do anything to bring Nexus or the Facility in breach of these obligations.
246. Accredited Practitioners will comply with all relevant legislation governing the collection, handling, security, storage and disclosure of health information, as well as notification of data breaches.
247. Accredited Practitioners will comply with common law duties of confidentiality.
248. Accredited Practitioners acknowledge that in order for the organisation to function, effective communication is required, including between the Nexus Board, CEO, CMO, Operations Directors, Nexus Executive, GM/DON, committees of the Facility, staff of the Facility and other Accredited Practitioners. Accredited Practitioners acknowledge and consent to communication between these persons and entities of information, including their own personal information, that may otherwise be restricted by the Privacy Act. The acknowledgment and consent is given on the proviso that the information will be dealt with in accordance with obligations pursuant to the Privacy Act and only for proper purposes and functions.

What Accredited Practitioners must keep confidential

249. Subject to By-Law 250, every Accredited Practitioner must keep confidential the following information:
    a. Commercially in confidence business information concerning Nexus and its Facilities;
    b. The particulars of these By-Laws;
    c. Information concerning the insurance arrangements of Nexus;
    d. Information concerning any patient, staff or other Accredited Practitioners; and
    e. Any information gained by or conveyed to the Accredited Practitioner in the course of committees or quality assurance activities.

When disclosure may occur

250. The confidentiality requirements of By-Laws 245 to 249 do not apply in the following circumstances:
    a. Where disclosure is required to provide continuing care to the patient;
    b. Where disclosure is required by law;
    c. Where disclosure is made to a regulatory or registration body in connection with an Accredited Practitioner;
    d. Where the person benefiting from the confidentiality consents to the disclosure or waives the confidentiality; or
    e. Where disclosure is required in order to perform some requirement of these By-Laws.

What confidentiality means

251. The confidentiality requirements of these By-Laws prohibit the recipient Accredited Practitioner of the confidential information from using it, copying it, disclosing it to someone else, reproducing it or making it public.

Confidentiality obligations continue

252. The confidentiality requirements of these By-Laws continue with full force and effect after the Accredited Practitioner ceases to be an Accredited Practitioner.

Section 11

ADMINISTRATIVE MATTERS

ADMINISTRATIVE MATTERS

FORMS AND PAPERWORK

Prescribed forms and paperwork

253. Nexus or a GM/DON may prescribe forms (written or electronic) and other administrative processes to be completed and performed by an Accredited Practitioner in the treatment of a patient in connection with the patient's admission to or treatment at a Facility.
254. An Accredited Practitioner must accurately complete those forms and perform those processes and then deal with them in accordance with the specified requirements.

Medical Advisory Committee

255. The MAC terms of reference will set out all matters relevant to the MAC.

DELEGATION

CEO may delegate

256. The CEO may delegate any of the responsibilities conferred upon them by these By-Laws at their complete discretion.

Section 12

DEFINITIONS

DEFINITIONS
In these By-laws, unless indicated to the contrary:

Accreditation means the process provided in these By-Laws by which a person is Accredited.

Accredited means the status conferred on a Medical Practitioner, Dentist, Allied Health Professional or other approved category of health practitioner to provide services within the Facility after having satisfied the Credentialing and Scope of Practice requirements provided in these By-Laws.

Accredited Practitioner means a Medical Practitioner, Dentist, Allied Health Professional or other approved category of health practitioner who has been Accredited to provide services within the Facility, and who may be an **Accredited Medical Practitioner, Accredited Dentist** or **Accredited Allied Health Professional**.

Adequate Professional Indemnity Insurance means insurance, including run off/tail insurance, to cover all potential liability of the Accredited Practitioner, that is with a reputable insurance company acceptable to the CEO or Facility Manager, and is in an amount and on terms that the CEO or Facility Manager considers in its absolute discretion to be sufficient. The insurance must be adequate for Scope of Practice and level of activity.

AHPRA means the Australian Health Practitioner Regulation Agency established under the *Health Practitioner Regulation National Law Act* 2009 (as in force in each State and Territory).

Allied Health Privileges means the entitlement to provide treatment and care to patients as an Allied Health Professional within the areas approved by the CEO or Facility Manager in accordance with the provisions of these By-Laws.

Allied Health Professional means a person registered by AHPRA as an Allied Health Professional pursuant to the *Health Practitioner Regulation National Law Act* 2009 as in force in each State and Territory in which the Facility is located, or other categories of appropriately qualified health professionals as approved by the CEO or Facility Manager.

Behavioural Sentinel Event means an episode of inappropriate or problematic behaviour which indicates concerns about an Accredited Practitioner's level of functioning and suggests potential for adversely affecting patient safety and welfare or organisational outcomes.

Behavioural Standards means the standard of conduct and behaviour expected of an Accredited Practitioner arising from personal interactions, communication and other forms of interaction with other Accredited Practitioners, employees of the Facility, Board members, executive of Nexus Day Hospitals or the Facility, third party service providers, patients, family members of patients and others. The minimum standard required of Accredited Practitioners in order to achieve the Behavioural Standards is compliance with the Code of Conduct (if any), policies in place at the Facility relating to behaviour, and the expectations set out in the *Good Medical Practice: A Code of Conduct for Doctors* in Australia (as applicable).

Board means the Board of Directors of Nexus Day Hospitals Pty Ltd.

By-Laws means these By-Laws.

Chief Executive Officer (CEO) means the person appointed to the position of Chief Executive Officer of Nexus Day Hospitals, or equivalent position by whatever name such as Managing Director, or any person acting, or delegated to act, in that position.

Clinical Practice means the professional activity undertaken by Accredited Practitioners for the purposes of investigating patient symptoms and preventing and/or managing illness, together with associated professional activities related to clinical care.

Code of Conduct means the relevant code of conduct in place at Nexus Day Hospitals.

Competence means, in respect of a person who applies for Accreditation or Re-Accreditation, that the person is possessed of the necessary knowledge, skills, training, decision making ability, judgment, insight, interpersonal communication and Performance necessary for the Scope of Practice for which the person has applied and has the demonstrated ability to provide health services at an expected level of safety and quality.

CMO means the Nexus Hospitals Chief Medical Officer

Credentials means, in respect of a person who applies for Accreditation or Re-Accreditation, the identity, education, formal qualifications, equivalency of overseas qualifications, post-graduate degrees / awards / fellowships / certificates, professional training, continuing professional development, professional experience, recency of practice, maintenance of clinical competence, current registration and status, indemnity insurance, and other skills/attributes (for example training and experience in leadership, research, education, communication and teamwork) that contribute to the Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care services at the Facility. This may include (where applicable and relevant) history of and current status with respect to Clinical Practice and outcomes during previous periods of Accreditation, disciplinary actions, By-Law actions, compensation claims, complaints and concerns – clinical and behavioural, professional registration and professional indemnity insurance.

Credentialing means, in respect of a person who applies for Accreditation or Re-Accreditation, the formal process used to match the skills, experience, and qualifications to the role and responsibilities of the position. This will include actions to verify and assess the identity, education, formal qualifications, equivalency of overseas qualifications, post-graduate degrees / awards / fellowships / certificates, professional training, continuing professional development, professional experience, recency of practice, maintenance of clinical competence, current registration and status, indemnity insurance, and other skills/attributes (for example training and experience in leadership, research, education, communication and teamwork) for the purpose of forming a view about their Credentials, Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care services within specific environments. 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 applicant for Accreditation or Re-Accreditation to carry out the Scope of Practice sought or currently held, including with the confidence of peers and the Facility, having regard to any relevant physical or mental impairment, disability, condition or disorder (including due to alcohol, drugs or other substances) which detrimentally affects or there is a reasonably held concern that it may detrimentally affect the person's capacity to provide health services at the expected level of safety and quality having regard to the Scope of Practice sought or currently held.

Dentist means, for the purposes of these By-Laws, a person registered as a dentist by the Dental Board of Australia governed by the AHPRA pursuant to the *Health Practitioner Regulation National Law Act* 2009 as in force in each State and Territory.

Disruptive Behaviour means aberrant behaviour manifested through personal interaction with Accredited Practitioners, hospital personnel, health care professionals, patients, family members, or others, which interferes with patient care or could reasonably be expected to interfere with the process of delivering quality care or which is inconsistent with the values of Nexus Day Hospitals or the Facility.

External Review means evaluation of the performance of an Accredited Practitioner by an appropriately qualified and experienced professional person(s) external to the Facility.

Facility means the hospital or facility of Nexus to which an application for Accreditation is made or an individual holds Accreditation.

General Manager/ Director of Nursing (GM/DON) means the person appointed to the position of manager of the particular Nexus Day Hospital, or equivalent position by whatever name, or any person acting, or delegated to act, in that position.

Internal Review means evaluation of the performance of an Accredited Practitioner by an appropriately qualified and experienced professional person(s) internal to the Facility.

Medical Advisory Committee (MAC) means the Medical Advisory Committee (or equivalent) of the Facility.

Medical Practitioner means, for the purposes of these By-Laws, a person registered as a medical practitioner by the Medical Board of Australia governed by the AHPRA pursuant to the *Health Practitioner Regulation National Law Act* 2009 as in force in each State and Territory.

New Clinical Services means clinical services, treatment, procedures, techniques, technology, instruments or other interventions that are being introduced into the organisational setting of the Facility for the first time, or if currently used are planned to be used in a different way, and that depend for some or all of their provision on the professional input of Accredited Practitioners.

Operations Director means persons appointed to the position of operations director for a Nexus Hospitals region, reporting to the Chief Operating Officer.

organisational capability means the Facility's ability to provide the facilities, services, clinical and non-clinical support necessary for the provision of safe, high quality clinical services, procedures or other interventions. Organisational Capability will be determined by the GM/DON's consideration of, but not limited to, the availability, limitations and/or restrictions of the services, staffing (including qualification and skill-mix), facilities, equipment, technology and support services required and by reference to the Facility's private health licence (where applicable), clinical service capacity, clinical services plan and clinical capability framework.

organisational need means the extent to which the GM/DON of the Facility considers it necessary to provide a specific clinical service, procedure or other intervention, or elects to provide a specific clinical service, procedure or other intervention, or elects to provide additional resources to support expansion of an existing clinical service, procedure or other intervention (including additional operating theatre utilisation), in order to provide a balanced mix of safe, high quality health care services that meet the Facility's consumer and community needs and aspirations. Organisational Need will be determined by, but not limited to, allocation of limited resources, clinical service capacity, funding, clinical services, strategic, business and operational plans, and the clinical services capability framework.

Performance means the extent to which an Accredited Practitioner provides, or has provided, health care services in a manner which is considered consistent with good and current Clinical Practice and results in expected patient benefits and outcomes. When considered as part of the Accreditation process, Performance will include an assessment and examination of the provision of health care services over the prior periods of Accreditation (if any).

Re-accreditation means the process provided in these By-Laws by which a person who already holds Accreditation may apply for and be considered for Accreditation following the probationary period or any subsequent term.

Scope of Clinical Practice means the extent of an individual Accredited Practitioner's permitted Clinical Practice within the Facility based on the individual's Credentials, Competence, Performance and professional suitability, and the Organisational Capability and Organisational Need of the organisation to support the Accredited Practitioner's scope of clinical practice. Scope of Practice may also be referred to as delineation of clinical privileges.

Specialist Medical Practitioner means a Medical Practitioner who has been recognised as a specialist in their nominated category for the purpose of the *Health Insurance Act 1973* (Cth) and has received specialist registration from the Australian Health Practitioner Regulation Agency.

Temporary Accreditation means the process provided in By-Laws whereby a Medical Practitioner, Dentist or Allied Health Professional is Accredited for a limited period.

Visiting Allied Health Professional means an Allied Health Professional who is not an employee of the Facility, and who has been granted Allied Health Accreditation and Scope of Practice pursuant to these By-Laws.

Visiting Dentist means a Dentist who is not an employee of the Facility, who has been granted Accreditation and Scope of Practice pursuant to these By-Laws.

Visiting Medical Practitioner means a Medical Practitioner who is not an employee of the Facility, who has been granted Accreditation and Scope of Practice pursuant to these By-Laws. Visiting Medical Practitioners include visiting Specialist Medical Practitioners.