PMA Facility Rules

PMA – September 2017

- CENTRAL COAST DAY HOSPITAL
- CHATSWOOD PRIVATE HOSPITAL
- COFFS DAY HOSPITAL
- EPPING SURGERY CENTRE
- MADISON DAY SURGERY

RATIFIED BY:	PMA Board & PMA Facility Boards
DATE:	September 2017
REVIEW DATE:	November 2020
PREVIOUS REVIEW:	2015, 2015, 2015

DATE	POLICY CHANGES
September 2017	• Updated with Madison Day Surgery and Coffs Day Hospital • Updated title of COO to CEO • CHATSWOOD
November 2015	• Updated with Chatswood Private Hospital & closure of Ophthalmic Surgery Centre & Sydney ENT & Facial Day Surgery Centre
May 2015	• New formatting applied throughout
January 2015	• Updated with SENT facility

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Foreword

These Facility Rules apply to all facilities operated by Presmed Australia (PMA) and at which the Board of the facility has determined they shall apply. PMA currently operates:

- Chatswood Private Hospital (Health Professionals previously accredited and credentialed at Ophthalmic Surgery Centre (North Shore) and Sydney ENT & Facial Day Surgery Centre continue to be accredited at Chatswood Private Hospital)
- Epping Surgery Centre
- Madison Day Surgery
- Central Coast Day Hospital (CCDH)
    - and within CCDH, Laser Vision Clinic Central Coast
- Coffs Day Hospital

The Facility Rules will assist in the selection and retention of Health Professionals who possess the qualifications and experience to deliver high quality health care to patients.

The Facility Rules require appropriate persons to:

- Examine the Credentials of various categories of Health Professions;
- Define and authorize a Scope of Clinical Practice for each Health Professional in each Facility in which they wish to Treat patients, which is appropriate to the Health Professional's competence and performance and the needs and capabilities of the Facility; and
- Undertake ongoing assessment at appropriate intervals of the competence and performance of each Health Professional and the needs and capabilities of each Facility in which they Treat patients, and, if necessary, re-define their authorized Scope of Clinical Practice in relation to each Facility.

The Facility Rules also define the roles of certain individuals and the composition, roles and responsibilities of various committees that assist PMA Facilities to maintain positive relationships with Accredited Health Professionals based on a mutual commitment to the delivery of high quality health care.

Compliance with the Facility Rules by all PMA Facilities staff and Accredited Health Professionals is mandatory.

1. THE FACILITY RULES

1.1 What are these Facility Rules?

This document sets out the current Facility Rules that apply to all hospitals and day procedure centres operated by PMA and at which the Board of each Facility has determined they shall apply.

These Facility Rules:

(a) implement the policies of the Board of each PMA Facility (PMAF); and

(b) are intended to inform those who will be affected by the Facility Rules.

1.2 Authority to make and amend these Facility Rules

(a) A PMAF Board is empowered to make Facility Rules and policies for the operation of its Facility as it may deem necessary from time to time.

(b) These Facility Rules are authorized by each PMAF Board and may be amended by the Board as it sees fit. A PMAF Board:

(1) may vary or revoke these Facility Rules at any time; and

(2) must review these Facility Rules at least every three (3) years.

1.3 The purposes of these Facility Rules

These Facility Rules have these purposes:

(a) to maintain and improve safety and quality of clinical care across all PMA Facilities;

(b) to endeavour to ensure consistency of safety and quality clinical care across all PMA Facilities:

(c) to define the relationship between PMA and its Accredited Health Professionals; and

(d) to assist in compliance with laws and standards.

1.4 Compliance with these Facility Rules

All PMA Facilities staff and Accredited Health Professionals are required to comply with these Facility Rules.

1.5 **Definitions of these Facility Rules**

Words or expressions which are capitalized have special meanings as follows:

Accreditation means:

(a) the authorization in writing by the Chief Executive Officer (CEO) for a Health Professional to Treat patients at the Facility within the Scope of Clinical Practice and in accordance with the conditions specified in that authorization; and

(b) the processes described in these Facility Rules leading to that authorisation.

Accreditation Classification means one of the nominated classification in clause 12.1.

Accreditation Notification means the formal notification from the CEO to a Health Professional advising the Health Professional of the PMAF Board's approval of their Accreditation or re-Accreditation and their authorized Scope of Clinical Practice.

Accredited Health Professional means a Health Professional who has been Accredited in accordance with these Facility Rules;

Accredited Practitioner means a Credentialed Medical Practitioner (CMP) or Dentist authorized to Treat patients at the Facility within a designated Scope of clinical Practice and in accordance with any specified conditions.

Act means the relevant State or Federal legislation which is intended to regulate private hospitals and/or day procedure centres in the State in which a Facility is located, including any regulations made pursuant to it.

Allied Health Professional means an orthoptist, optometrist, cardiac technician, chiropractor, dietician, occupational therapist, pharmacist, physiotherapist, podiatrist, psychologist, speech pathologist, social worker, rehabilitation counselor or other category of person who provides allied health services, as determined by the PMAF Board. For the purpose of these Facility Rules, a reference to an Allied Health Professional includes any Complementary Health Provider and a reference to allied health services includes complementary health services.

Application Form means the application form approved by PMA Facilities from time to time to be used by Health Professionals to apply for Accreditation.

Board means the board of each respective PMAF.

Career Medical Officer means a Medical Practitioner who is employed or contracted by the Facility to Treat patients within a designated Scope of Clinical Practice in consultation with an Accredited Practitioner.

Chief Executive Officer (CEO) means the person appointed by the PMA Managing Director as the Chief Executive Officer of PMA Facilities and in the absence of that person, the person appointed to act in that position for the time being.

Clinical Department means a department or section of Accredited Practitioners in like medical fields, as approved by the CEO on the advice of the Medical Council in accordance with clause 5.1.

Clinical Manager/Director of Nursing means the person employed by a Facility and/or appointed to that position by the CEO in consultation with the Managing Director and in the absence of that person, the person appointed to act in that position for the time being.

Clinical Review Committee means the MAAC established in accordance with Rule 32.1, or such other committee, howsoever described, performing the functions of that committee.

Complementary Health Provider means a naturopath, homeopath, acupuncturist or other category of person providing alternate health services, as determined by the PMAF Board.

Consultant Emeritus means a Medical Practitioner or Dentist who has provided distinguished service to the Facility or who otherwise is a Medical Practitioner or Dentist of outstanding merit or extraordinary accomplishment and who is designated formally by the PMAF Board as an Accredited Practitioner in the category of Consultant Emeritus.

Credentialing means the formal process used to verify the Credentials of Health Professionals for the purpose of forming a view as to their competence, performance and professional suitability to provide safe, high quality health care services in accordance with the needs and capabilities of the Facility.

Credentials means the qualifications, registration with the appropriate government authorities and professional bodies, professional training, clinical experience and training and experience in leadership, research, education, communication and teamwork that contribute to a Health Professional's competence, performance and professional suitability to provide safe, high quality health care services.

Credentials Committee means the MAAC established in accordance with Rule 31.1(b), or such other committee, howsoever described, performing the functions of that committee.

Current Fitness means the current fitness required of a Health Professional to carry out the Scope of Clinical Practice sought or currently approved. A person is not to be considered as having Current Fitness if that person suffers from any physical or mental impairment, disability, condition or disorder which detrimentally affects or is likely to detrimentally affect their physical or mental capacity to practice medicine or dentistry or allied health or nursing services (as the case may be) and carry out the Scope of Clinical Practice sought or granted. Misuse of alcohol or other drugs is considered to be a physical or mental disorder for the purposes of these Facility Rules.

Dentist has the same meaning as in the applicable Federal or State registration act for dentists.

Director of Medical Services means, if the CEO after consultation with the Managing Director decides to make an appointment to such a position, the Medical Practitioner employed by a Facility and/or appointed to that position and in the absence of that person, the person appointed to act in that position for the time being.

Executive Management Committee means the QRC established in accordance with Rule 8.

Facility means a hospital or day procedure centre of PMA at which the Board has determined that these Facility Rules shall apply.

Federal government, department or body means the government of the Commonwealth of Australia, a department of that government or other body carrying out a national function in Australia.

Facility Rules means these Facility Rules as amended from time to time.

Fellow Practitioner means a Medical Practitioner who may or may not yet be recognized either as a Specialist Practitioner in their nominated category or as a General Practitioner for the purposes of the Health Insurance Act 1973 (Cth) and with no admitting rights, but who is undertaking advanced training in a specialist area and working under the supervision of a Specialist Practitioner or a General Practitioner (as appropriate).

General Conditions means the conditions of Accreditation set out in Schedule 1 of these Facility Rules, as amended from time to time.

General Practitioner means a Medical Practitioner who is recognized as a general practitioner for the purposes of the Health Insurance Act 1973 (Cth) and who is registered as such by the relevant Federal or State registration body.

Health Department means the State and/or Federal government department with responsibility for health.

Health Professional means:

(a) a Medical Practitioner;

(b) a Dentist;

(c) an Allied Health Professional;

(d) a Nurse First Assistant;

(e) a Nurse Practitioner; or

(f) any other category, approved by the Board, of persons who provide

(g) health services.

Human Research Ethics Committee (HREC) means a committee established to review proposals for research involving humans, which is registered with the National Health and Medical Research Council (NHMRC) and which is established and functions in accordance with NHMRC Guidelines.

Managing Director means the person appointed as the Managing Director of PMA and in the absence of that person, the person appointed to act in that position for the time being.

Medical Advisory & Audit Committee (MAAC) means a committee established in accordance with Rule 30.1.

Medical Board means the registration board for Medical Practitioners in the State or any similar Federal body.

Medical Council means the council, if instituted by the CEO, described in Rule 29.1, comprised of all Accredited Practitioners of the Facility (except Surgical Assistants, Career Medical Officers, Registrars and Fellow Practitioners).

Medical Executive means the chairperson and deputy chairperson/secretary of the Medical Council of the Facility and the Director of Medical Services if one has been appointed to the Facility.

Medical Practitioner has the meaning given in the applicable State registration act, or Federal registration act if such an act has precedence over a State act, for medical practitioners in the State.

New Clinical Services, Procedures or Other Interventions means clinical services, procedures or equipment that are new to the Facility, require more than incremental change in the way in which health care services are delivered at the Facility and:

(a) have been established in other organizational settings and are deemed by a responsible body of medical opinion as clinical services, procedures or other interventions that will benefit patients;

(1) may involve the use of equipment that has not previously been used at the Facility, or has not been used in the way now proposed; or

(2) the new service, procedure, equipment or new method of using the equipment requires specific training of staff at the Facility or raises a risk to patient safety in the opinion of CEO, acting reasonably.

They may, but will not necessarily, be innovative, complex or costly. For clarity, this does not include services or procedures that are experimental or equipment or devices that do not have Therapeutic Goods Act (TGA) or equivalent approval, which would fall within the definition of Research.

Nurse First Assistant howsoever described means a nurse who is registered as such by the relevant Federal or State registration body who assists an Accredited Practitioner in the operating theatre or elsewhere at the Facility and has undertaken graduate training appropriate to the position in which they are assisting.

Nurse Practitioner means a nurse who is registered as such by the relevant Federal or State registration body, who is educated and authorized to function autonomously and collaboratively in an advanced and extended clinical role.

Presmed Australia means Presmed Australia Pty Limited (ACN 077 299 104) and its subsidiaries and controlled entities.

Quality Review Committee (QRC) means the Committee established by the Managing Director to advise on policy, procedures and operational matters relevant to accountability, governance and for the safety and quality of clinical care in the Facilities of PMA.

Re-credentialing means the formal process to review the qualifications, experience, professional standing and other relevant professional attributes of Accredited Practitioners and Accredited Allied Health Professionals for the purpose of forming a view about their ongoing competence, performance and professional suitability to continue to provide safe, high quality health services in accordance with the needs and capabilities of the Facility.

Registrar means a Medical Practitioner without specialist qualifications or admitting rights who is generally participating in a recognized training program in preparation for qualifying as a Specialist Practitioner.

Research includes investigation undertaken to gain knowledge and understanding or to train researchers and includes:

(a) Treatment that remains experimental, whether or not subject to review by a properly constituted Human Research Ethics Committee; or

(b) innovations in Treatment or investigation methods, equipment or technology.

Review Committee means a committee established in accordance with Rule 22.2.

Scope of Clinical Practice (sometimes called clinical privileges) means the extent of clinical practice which an Accredited Health Professional is authorized to undertake within the Facility based upon the individuals' credentials, competence, performance and professional suitability and the needs and capability of the Facility. A Scope of Clinical Practice may include the use of facilities or specialized equipment of the performance of specific operations or procedures. The Scope of Clinical Practice granted to an Accredited Health Professional may vary from one Facility to another.

Specialist Practitioner means a Medical Practitioner who has been recognized as a specialist in their nominated category for the purposes of the *Health Insurance Act 1973* (Cth), is recognized by the relevant specialist college and who is registered as such by the relevant Federal or State registration body.

Staff Specialist means a Specialist Practitioner employed or contracted by, or seconded to, the Facility.

State means the state (or if applicable, territory) in which the Facility operates.

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

Treat (or Treating) means to attend or administer to a patient in a professional manner and includes any clinical intervention, assessment, diagnosis, consultation, attendance on, or assistance in the Treatment of a patient.

Treatment means an act or manner of Treating a patient (within the meaning of the definition **Treat**) by a Health Professional or, where appropriate, may refer to a course of clinical intervention or management prescribed by a Health Professional for a patient.

1.6 **Interpretation**

(a) In the interpretation of these Facility Rules, the following provisions apply unless the context requires otherwise:

(1) headings are inserted for convenience only and do not affect the interpretation of these Facility Rules;

(2) a reference in these Facility Rules to any law, legislation or legislative provision includes any statutory modification, amendment or re-enactment, and any subordinate legislation or regulations issued under that legislation or legislative provision;

(3) a reference to a clause, part, schedule or attachment is a reference to a clause, part, schedule or attachment of or to these Facility Rules;

(4) where a word or phrase is given a defined meaning, another part of speech or other grammatical form in respect of that word or phrase has a corresponding meaning;

(5) a word which denotes the singular also denotes the plural, a word which denotes the plural also denotes the singular and a reference to any gender also denotes the other gender;

(6) a reference to the word “include” or “including” is to be construed without limitation;

(7) a reference to the Treatment of patients “at the Facility” includes a reference to Treatment provided at the Facility or provided or arranged with the direct involvement of the Facility within the meaning of section 121.5 of the *Private Health Insurance Act 2007* (Cth);

(8) any schedules and attachments form part of these Facility Rules; and

(9) for the purposes of Facility Rules 10.10, 14.9, 19.2, 19.3, 25.2, 25.3, 30.2(e), 30.4(a), 30.4(b), 30.5(c) and 30.5(f), references to the chairperson of the MAAC are taken to include, where the chairperson is unavailable, either the deputy chairperson of the MAAC or a member of the MAAC representing the relevant specialty.

(b) Where the title chairperson is used in these Facility Rules, the incumbent of that position for the time being may choose to use whichever designation that person so wishes.

2. QUORUM/MEETINGS

2.1 Where these Facility Rules refer to a meeting (with the exception of the Medical Council) the following quorum requirements shall apply:

(a) where there is an odd number of members of the committee or group, a majority of the members; or

(b) where there is an even number of members of the committee or group, one half of the number of the members plus one.

2.2 A decision may be made by a committee or group established pursuant to these Facility Rules (except the Review Committee established by Rule 22.2) without a meeting if a consent in writing setting forth such a decision is agreed by the majority of members attending the committee or group, as the case may be.

2.3 A committee or group established pursuant to these Facility Rules may permit members to participate in a particular meeting, or all meetings, by telephone, close-circuit television or other means of communication. The requirements of these Facility Rules shall nonetheless apply to such a meeting.

3. VOTING

3.1 Where voting on an issue is performed pursuant to these Facility Rules, the vote of a simple majority of those present will determine the issue.

3.2 Unless otherwise provided in these Facility Rules, if there is an equality of votes the chairperson shall have a casting vote in addition to a deliberative vote.

3.3 Proxy voting is not permitted.

4. DISPUTES

Any dispute or difference which may arise as to the meaning or interpretation of these Facility Rules or as to the powers of any committee or the validity of proceedings of any meeting shall be determined by the PMAF Board at which the dispute relates.

5. CHIEF EXECUTIVE OFFICER

5.1 The PMA Managing Director (MD) shall appoint a Chief Executive Officer (CEO) of the Facility.

5.2 The CEO shall:

(a) be the senior officer of the Facility to whom all staff, through their respective department heads, shall be responsible;

(b) be the spokesperson and, other than in exceptional circumstances, the channel for all formal communications to and from the Facility;

(c) advise the MD and PMAF Board on matters relating to the purchase of major equipment;

(d) be responsible for the management of the Facility and its staff and resources, including the provision of patient care to acceptable standards, in accordance with the policies and directives of the PMAF Board;

(e) ensure due observance of the Act, all other statutes, these Facility Rules and all other legal requirements; and

(f) act as Secretary to the Medical Council (if instituted), MAAC and Credentials Committee; however the CEO may delegate such roles.

5.3 The availability of Facility resources (including staff and physical facilities) and any obligation of any Accredited Practitioner to participate in Facility rosters will be at the absolute discretion of the CEO and may change from time to time. The availability or allocation of theatre sessions will be reviewed by the CEO on an ongoing basis. The CEO has absolute discretion to allocate and to change the allocation of theatre sessions, taking into account matters including but not limited to:

(a) the availability of theatres and nursing staff;

(b) commercial strategies and priorities of the Facility and/or PMA;

(c) Facility and/or PMA policy;

(d) the utilization of sessions allocated previously to that Accredited Practitioner, including adherence to allocated session starting times; and/or

(e) the case mix of that Accredited Practitioner and the Facility.

5.4 The CEO with the advice of the Medical Council (if instituted) may establish Clinical Departments of Accredited Practitioners to facilitate achievement of the Facility's objectives. The Accredited Practitioners of Clinical Departments will meet no less often than MAAC meetings are held.

5.5 The CEO following consultation with the Medical Council shall appoint heads of the Clinical Departments to hold office at the discretion of the CEO.

6. CLINICAL MANAGER/DIRECTOR OF NURSING AND DIRECTOR OF MEDICAL SERVICES

6.1 The CEO after consultation with the MD shall appoint a Clinical Manager/Director of Nursing and may appoint a Director of Medical Services on such terms and conditions as are consistent with statutory and licensing requirements and the requirements of the Facility for clinical leadership and management.

6.2 The CEO has responsibility and accountability for all of the following functions and may delegate to the Clinical Manager/Director of Nursing and/or the Director of Medical Services responsibility and accountability for any or all of:

(a) ensuring that suitable standards (including but not limited to clinical standards) are maintained to provide a satisfactory and safe environment for patients, staff, Accredited Health Professionals and others;

(b) liaising within the Facility and with the QRC about issues of clinical safety, quality and standards;

(c) advising on matters of policy in clinical services referred by the PMAF Board or the QRC;

(d) overseeing the process of Accreditation including Credentialing and defining the Scope of Clinical Practice of Health Professionals;

(e) ensuring that medical, nursing and other resources are provided at a level that will ensure a safe and optimal level of patient care;

(f) in accordance with Rule 5.2(f), acting as Secretary to the Medical Council (if instituted), MAAC and Credentials Committee;

(g) ensuring compliance with relevant statutory requirements;

(h) participating actively in all activities of the QRC (Executive Management Committee);

(i) as required, cooperating in the planning of additional facilities and services; and

(j) ensuring availability at all times, either personally or by delegation of authority, to meet any emergency or contingency that may arise.

7. EXECUTIVE STAFF

The CEO may appoint and remove any other executive staff he or she deems appropriate for the Facility and may determine the role and duties of such appointees.

8. QUALITY REVIEW COMMITTEE (EXECUTIVE MANAGEMENT COMMITTEE)

8.1 The QRC (performing the functions of the Executive Management Committee) shall comprise:

(a) the CEO;

(b) each Clinical Manager/Director of Nursing;

(c) each Director of Medical Services, if appointed;

(d) other executive staff appointed under Rule 7; and

(e) any other person by invitation of the CEO.

8.2 The CEO shall convene the QRC on a regular basis.

8.3 The QRC shall advise the CEO on operational and strategic matters relevant to the Facility including but not limited to financial, human resources and clinical matters.

9. OTHER FACILITY COMMITTEES

9.1 The CEO may establish other committees for the purposes of the Facility.

9.2 Subject to these Facility Rules, the CEO shall determine the membership, powers, authorities and responsibilities that are delegated to each committee and the administrative Facility Rules by which each committee is to operate.

10. RELATIONSHIP OF PRESMED AUSTRALIA FACILITIES TO HEALTH PROFESSIONALS

10.1 The requirements for Accreditation defined in these Facility Rules apply to:

(a) all Medical practitioners and Dentists other than those employed by the Facility and subject to the Facility's performance management procedures, or those seconded to the Facility; and

(b) all Allied Health Professionals, Nurse First Assistants and Nurse Practitioners, other than those who are employed by the Facility and subject to the Facility's performance management procedures, or those seconded to the Facility.

10.2 Subject to any specific exemption under these Rules, a Health Professional may treat patients at the Facility only if he or she has been accredited by the PMAF Board to do so unless the Health

Professional is employed by or seconded to the Facility and therefore exempted from Accreditation under Rule 10.1. An employed Health Professional must comply, to the extent relevant, with the Facility Rules.

10.3 Prior to offering employment to a Health Professional, the CEO must have undertaken pre-employment checks in accordance with PMAF policy and must be satisfied that the Health Professional holds appropriate Credentials and current registration with the relevant State or Federal registration board.

10.4 Every applicant for Accreditation must acknowledge in writing that he/she will comply with and be bound by these Facility Rules as amended from time to time, and by codes of conduct or codes of behaviour adopted by the PMAF and/or by PMA from time to time.

10.5 A Health Professional may be accredited to Treat patients at the Facility for a period of up to five (5) years. The period of Accreditation shall be specified in the Accreditation Notification.

10.6 The CEO must not notify a Health Professional that he/she is Accredited or re-Accredited unless the CEO is satisfied that:

(a) the Credentials and insurance of the applicant have been reviewed and validated according to the Facility Rules and PMAF policy; and

(b) the Board has approved the Accreditation or re-Accreditation and Scope of Clinical Practice of the Health Professional.

10.7 An Accredited Health Professional may Treat patients at the Facility:

(a) only within the Scope of Clinical Practice specified in the Accreditation Notification;

(b) only if he/she has provided evidence of his/her current registration and insurance to the CEO or Clinical Manager/Director of Nursing of the Facility; and

(c) subject at all times to the directions of the CEO.

10.8 The CEO or his/her authorized delegate may refuse or withdraw permission for an Accredited Health Professional to use the Facility for the Treatment of a patient if, in the CEO's opinion, the proposed Treatment:

(a) cannot be provided by the Accredited Health Professional and/or supported by the Facility at an appropriate standard of safety and quality;

(b) is outside the authorized Scope of Clinical Practice of the Accredited Health Professional;

(c) is likely to result in damage to the reputation of the Facility and/or PMA; or

(d) is inconsistent with good professional practice.

10.9 The Accreditation of a Health Professional is personal and cannot be transferred to or exercised by any other person.

10.10 It is acknowledged that the national *Health Practitioner Regulation National Law (NSW) 2009* (and the corresponding law as adopted in each State) requires an employer of a medical practitioner to report certain conduct undertaken by and/or circumstances surrounding the performance of a medical practitioner. The PMAF Board may, via the CEO, following consultation with the chairperson of the MAAC, the QRC and the PMA legal advisors, also report certain conduct or circumstances to the relevant Federal or State health complaints entities or professional registration bodies in its absolute discretion in accordance with the national *Health Practitioner Regulation National Law (NSW) 2009.*

11. MEDICAL ADVISORY & AUDIT COMMITTEE (CREDENTIALS COMMITTEE)

11.1 The Managing Director shall establish a MAAC at each PMAF to undertake the functions of the Credentialing Committee which:

(a) may, to the extent delegated by the PMAF Board, make decisions; and

(b) shall be responsible for advising the PMAF Board, on general and specific matters relevant to Credentialing, Scope of Clinical Practice; and

(c) Performance reviews of Accredited Practitioners.

12. ACCREDITATION OF MEDICAL PRACTITIONERS AND DENTISTS

12.1 Accreditation Classifications

(a) Each Accredited Practitioner shall be designated one or more of the following Accreditation Classifications:

(1) Career Medical Officer;

(2) Consultant Emeritus;

(3) Dentist;

(4) Fellow Practitioner;

(5) General Practitioner;

(6) Registrar;

(7) Specialist Practitioner;

(8) Staff Specialist;

(9) Surgical Assistant.

An Accredited Practitioner that is Accredited for more than one Facility may be designated different Accreditation Classifications for the different Facilities.

12.2 The conditions associated with each of the Accreditation Classifications are detailed in Schedule 2 to these Facility Rules.

12.3 Each Medical Practitioner or Dentist who applies for Accreditation must apply for approval of a Scope of Clinical Practice within one or more of the following broad categories:

(a) Non-surgical care;

(b) Surgical care;

(c) Surgical assisting;

(d) Anaesthesia (age range to be specified for paediatrics as below)

Anaesthetists electing to be accredited for paediatrics must nominate the age range/s below, qualifications/experience in paediatric anaesthesia and the frequency of paediatric lists at a hospitals providing children's services:

☐ 28 days to 1 year

☐ 1 year to 2 years

☐ 2 years to 8 years

☐ 8 years to 14 years

(e) Diagnostic, interventional and/or procedural services;

(f) Consulting services.

(g) Other: (any specific scope of practice conditions)

13. INITIAL ACCREDITATION AS A MEDICAL PRACTITIONER OR DENTIST

13.1 A Medical Practitioner or Dentist who wishes to be accredited to Treat patients at a Facility must submit a completed Application Form to the CEO.

13.2 A Medical Practitioner or Dentist may apply for Accreditation to multiple Facilities using a single Application Form and may provide a single set of documents evidencing his/her Credentials, where authorized by the CEO.

13.3 The CEO may reject any application for Accreditation to a Facility. The CEO shall not be required to give reasons for his/her decision and there shall be no right of review against a decision of the CEO to reject an application for Accreditation.

13.4 The CEO shall only accept an application for Accreditation if the services proposed to be provided are likely to meet the needs of the Facility and are aligned closely with its capability, recurrent operating plan and long-term strategic directions.

13.5 The CEO must ensure compliance with PMAF policy that requires applicants to provide three (3) written professional references in the form required by any such policy. One referee must be a senior manager in a hospital or day procedure centre within which the applicant has worked recently.

13.6 The CEO must ensure that the following have been verified:

(a) the applicant holds appropriate registration with the relevant Federal and/or State registration board;

(b) the applicant holds appropriate professional indemnity insurance in accordance with PMA policy; and

(c) reference checks must be completed by the CEO, Chairperson of the MAAC, and a member of the MAAC representing the relevant medical specialty group for at least 2 of the three professional referees listed in the applicant's application.

13.7 If the applicant lists referees that are already Accredited to a Facility, then a template reference check letter is used for the referee to document, complete and return to the CEO.

13.8 For all other referees, a verbal reference check is to be conducted and a template report form is used to document the results.

13.9 These referee checks must be conducted in addition to any other references required under Rule 13.5.

13.10 If the CEO accepts the application for Accreditation, he or she shall refer it to the Credentials Committee, together with notes of any reference checks carried out under Rules 13.5, 13.6(c) and 13.7 and his/her recommendations regarding the application.

13.11 The Credentials Committee shall review all applications referred to it with respect to the Credentials, qualifications, experience, competence, judgment, professional capabilities and knowledge, current fitness and character of and confidence held in the applicant and formulate recommendations to the CEO on the applicant's Credentials, appropriate Accreditation Classification and Scope of Clinical Practice.

13.12 The Credentials Committee, to the extent that authority to do so is delegated by the PMAF Board under Rule 11.1(a), determine whether and under what conditions Accreditation should be offered in accordance with Rules 13.14, 13.15 and 13.18, shall recommend to the CEO whether the application for Accreditation should be approved and if so, the appropriate Accreditation Classification and Scope of Clinical Practice for the applicant.

13.13 The CEO must consider every recommendation of the Credentials Committee. The CEO shall submit the recommendations of the Credentials Committee together with the CEO's advice on Accreditation including Scope of Clinical practice to the Board of the respective facility.

13.14 The PMAF Board retains discretion to determine whether Accreditation is to be offered and under what conditions, taking into account factors including but not limited to the workforce need, the capacity, capability and strategic direction of the facility and the Credentials, assessed qualifications, experience, competence, judgment, professional capabilities and knowledge, Current Fitness and character of and confidence held in the applicant for Accreditation.

13.15 The PMAF Board may qualify the conditions of Accreditation in any way including but not limited to a limited period of Accreditation, a limited Scope of Clinical Practice, a requirement for a mentoring or supervision program, a periodic performance review, a periodic review of Scope of Clinical Practice and/or a performance management program.

13.16 The CEO must notify the applicant of the decision of the PMAF Board or the Credentials Committee. If the Accreditation Notification confirms the Accreditation of the applicant, then it must set out the particulars of the Accreditation including the Accreditation Classification, the period of Accreditation, the authorized Scope of Clinical Practice and any other conditions that will apply.

13.17 There shall be no right to seek a review of a decision of the PMAF Board or the Credentials Committee concerning the initial Accreditation (or refusal of Accreditation) or Scope of Clinical Practice of a Medical Practitioner of Dentist.

13.18 The Accreditation period shall be determined by the PMAF Board, subject to any maximum period prescribed by law but shall not exceed five (5) years. .

13.19 During the period of Accreditation, an Accredited Practitioner must provide evidence of the following, annually to the CEO and the CEO or his/her authorized delegate must verify that:

(a) the Accredited Practitioner holds appropriate registration with the relevant Federal and/or State registration board(s); and

(b) the Accredited Practitioner holds appropriate professional indemnity insurance in accordance with PMAF policy and standards.

13.20 An Accredited Practitioner must comply with the conditions of the Accreditation and these Facility Rules. Accreditation is subject at all times to the Accredited Practitioner complying with the General Conditions of Accreditation set out in Schedule 1 of these Facility Rules, as amended from time to time. If there is any inconsistency between those General Conditions of Accreditation and any special conditions, the special conditions prevail.

14. TEMPORARY ACCREDITATION

14.1 The CEO (or the Director of Medical Services, where one has been appointed, with the delegated authority of the CEO) may authorize temporary Accreditation of a Medical Practitioner or Dentist, whether before an application for Accreditation has been determined or at any other time. The CEO must comply with Facility Rules 14.2, 14.3 and 14.4 prior to issuing temporary Accreditation or as soon as practicable after temporary Accreditation is granted.

14.2 The CEO must comply with PMAF policy that requires specified Credentials to be reviewed and/or verified for the purposes of a temporary Accreditation, including any policy regarding the number and format of professional references to be obtained and reviewed.

14.3 The CEO must verify, before temporary Accreditation is granted, that:

(a) the applicant holds appropriate registration with the relevant Federal and/or State registration board(s); and

(b) the applicant holds appropriate professional indemnity insurance in accordance with PMAF policy and standards.

14.4 The CEO or delegate must confer with the chairperson or a member of the Credentials Committee and/or the head of the relevant Clinical Department (if one has been established) after conducting referee checks in accordance with Facility Rules 13.5, 13.6(c) and 17 before

authorizing temporary Accreditation, including an associated Accreditation Classification and temporary Scope of Clinical Practice.

14.5 The CEO may approve temporary Accreditation on a case by case basis for a specified period of up to six (6) months from the date of advice to the applicant that the temporary Accreditation has been approved. The CEO must specify a Scope of Clinical Practice and may attach conditions to the Accreditation at his/her discretion.

14.6 Temporary Accreditation enables a Medical Practitioner or Dentist to Treat patients at the Facility within the specified Scope of Clinical practice and any associated conditions, until a final determination of an application for Accreditation is made or until a specified date or until a specified occurrence.

14.7 Temporary Accreditation does not create a right to or expectation that the same or similar temporary Accreditation will be granted at any other time, or that full Accreditation will be granted at any stage.

14.8 A Medical Practitioner or Dentist who Treats patients at the Facility under temporary Accreditation must comply with the terms of the Accreditation and these Facility Rules. Temporary Accreditation is subject at all times to the Accredited Practitioner complying with the General Conditions of Accreditation set out in Schedule 1 of these Facility Rules, as amended from time to time. If there is any inconsistency between those General Conditions of Accreditation and any special conditions, the special conditions prevail.

14.9 Following consultation with the chairperson of the Credentials Committee, the CEO may suspend or terminate a temporary Accreditation at any time for any reason, including but not limited to the CEO holding the opinion that patient care or safety, staff welfare or safety or the interests or reputation of the Facility or Presmed Australia may be impaired if the temporary Accreditation continues.

14.10 There shall be no right to seek a review of any aspect of a decision of the CEO concerning the temporary Accreditation or associated Scope of Clinical Practice of a Medical Practitioner or Dentist.

15. ACCREDITATION OF LOCUM TENENS

If an Accredited Practitioner nominates a locum tenens to provide services to his/her patients during a period of absence from the Facility, that nominee cannot Treat patients at the Facility unless and until the CEO has approved their Accreditation (or temporary Accreditation as applicable).

16. RE-ACCREDITATION, RE-CREDENTIALING AND RE-DEFINING SCOPE OF CLINICAL PRACTICE

16.1 Not less than three (3) months before the date fixed for expiry of the Accreditation of a Health Professional, the CEO must notify the Accredited Practitioner of the pending expiry of their Accreditation and the processes for applying for re-Accreditation, including Re-Credentialing and review of their Scope of Clinical Practice.

16.2 An Accredited Practitioner who wishes to renew their Accreditation must apply for re-Accreditation before the expiration of the term of Accreditation. If the Accredited Practitioner does not re-apply for Accreditation until after the date on which his/her Accreditation expires or at all, his/her accreditation is revoked from the date of expiry and the application process for initial Accreditation as prescribed by Facility Rules 13.1 to 13.17 will apply.

16.3 Subject to PMAF policy, the processes for re-Accreditation, including processes for Re-credentialing and re-defining the Scope of Clinical Practice of Accredited Practitioners shall be the same as for an initial Accreditation, save that Rule 13.17 does not apply.

16.4 All accredited Practitioners shall be subject to the processes of re-Accreditation, Re-credentialing and review of their Scope of Clinical Practice at least once every five (5) years.

17. RESIGNATION OR EXTENDED ABSENCE OF AN ACCREDITED PRACTITIONER

17.1 An Accredited Practitioner who intends to cease Treating patients at the Facility either indefinitely or for an extended period must provide a reasonable period of written notice of his/her intention to the CEO. Accreditation shall be taken to be relinquished from the date specified in the notification.

17.2 An Accredited Practitioner to whom Rule 17.1 applies must, as soon as practicable, advise the CEO prior to the cessation of his/her normal patient bookings and clinical activities and must ensure that upon cessation of clinical activities, any remaining patients are either discharged or referred with appropriate consent to the care of another Health Professional to ensure continuous cover.

17.3 It is the responsibility of each Accredited Practitioner to advise their patients and any known carers or legal guardians of their patients of any proposed changes to their care arrangements.

18. ACCREDITED PRACTITIONER MAY REQUEST VARIATION OF SCOPE OF CLINICAL PRACTICE

18.1 An Accredited Practitioner may request a variation to his/her Scope of Clinical Practice.

18.2 The processes for variation of Scope of Clinical practice are the same as for an initial determination of Scope of Clinical Practice. However, if the CEO is satisfied that there has been no change to those Credentials since the date on which the Accredited Practitioner's Scope of Clinical Practice was last determined, the CEO may waive the requirement for the Accredited Practitioner to submit evidence of specific credentials.

19. REVIEW OF SCOPE OF CLINICAL PRACTICE/ACCREDITATION CLASSIFICATION/CONDITIONS OF ACCREDITATION

19.1 At any time, any of the CEO, the Clinical Manager/Director of Nursing, the Director of Medical Services (if appointed), the chairperson of the Credentials Committee, the head of a Clinical Department in which an Accredited Practitioner practices (if applicable), the QRC or the PMAF Board may request a review of the Scope of Clinical Practice, or of the Accreditation Classification or conditions of Accreditation of an Accredited Practitioner. Where a review is requested, it may be carried out by independent persons under Rule 19.2 or by the Credentials Committee under Rule 19.3.

19.2 The CEO, following consultation with the chairperson of the MAAC, may elect to commission a review of any or all of the Scope of Clinical Practice, Accreditation Classification or conditions of Accreditation of the Accredited Practitioner by an independent person or persons. The review must be undertaken in a timely manner and may include but need not be limited to consideration of the Credentials, competence, performance and Current Fitness of the Accredited Practitioners; an assessment of confidence in the Accredited Practitioner; and an assessment of the needs and capability of the Facility insofar as they are related to the Accredited Practitioner's Scope of Clinical Practice, Accreditation Classification, and/or conditions of Accreditation.

19.3 If the CEO elects not to commission an independent review under Rule 19.2, he or she shall refer the request for review of the Scope of Clinical Practice, Accreditation Classification, and or conditions of Accreditation of an Accredited Practitioner to the Credentials Committee, which shall conduct the review according to its usual processes for Credentialing and defining the Scope of Clinical Practice, Accreditation Classification and conditions of Accreditation and advise the PMAF Board of its recommendations.

19.4 The Accredited Practitioner who is the subject of a review under Rule 19.2 or 19.3 must:

(a) be informed in writing of the proposed review including reasonable particulars about any issues of concern and the potential outcomes of the review;

(b) be provided with a copy of the current Facility Rules for the Facility (or Facilities) at which the Accredited Practitioner practises;

(c) be provided with an opportunity to make a written submission to the reviewer; and

(d) co-operate with the reviewers, including providing information reasonably requested to inform the review.

19.5 Following consultation between the CEO and the Credentials Committee, the results of the review together with recommendations shall be submitted to the PMAF Board. The PMAF Board shall take appropriate action which may include termination of the Accreditation, revision of the Accreditation Classification or conditions of Accreditation or Scope of Clinical practice of the Accredited Practitioner or imposition of conditions on the Accreditation.

19.6 The CEO, having consulted with the PMAF Board and the PMA Legal Counsel, shall advise the Accredited Practitioner in writing within five (5) working days of the PMAF Board's decision and shall implement the decision immediately (or at such other date as recommended by the PMAF Board).

19.7 Subject to rights of review on the part of the Accredited Practitioner under Rules 22.1 to 22.9, any variation in an Accredited Practitioner's Accreditation Classification, conditions of Accreditation or Scope of Clinical practice constitutes a consequential variation to the Accreditation of the Accredited Practitioner at all PMA Facilities at which Accreditation is held, unless otherwise determined and notified by the PMAF Board.

20. SUSPENSION OF ACCREDITATION

20.1 The CEO, following consultation with the chairperson of the MAAC, the PMAF Board and the PMA Legal Counsel (whether or not arising out of a review under Rule 19.2 or 19.3), may by notice in writing suspend the Accreditation of an Accredited Practitioner (in part of in full and on whatever terms) until further notice if in the opinion of the CEO:

(a) to do so would be in the interest of patient care or safety;

(b) to do so would be in the interests of staff welfare or safety;

(c) the Accredited Practitioner has materially breached any conditions of Accreditation, including failing to comply with these Facility Rules (as amended from time to time);

(d) the conduct or continuing Accreditation of the Accredited Practitioner compromises the efficient operation or any interests of the Facility or of PMA;

(e) the conduct of the Accredited Practitioner is likely to harm the reputation of the Facility and/or of PMA; or

(f) serious issues of concern (not otherwise falling within Rule 20.1(a) to 20.1(e)) have been raised in relation to the Accredited Practitioner such as the Accredited Practitioner has been convicted or pleaded guilty to a criminal offence (excluding driving offences that do not result in a prison term) including a serious sex or violence offence or an offence involving dishonesty or drugs.

20.2 Where a review under Rules 19.2 or 19.3 has not been conducted before suspending an Accredited Practitioner's Accreditation, or if in the CEO's opinion (having consulted with the Credentials Committee, the PMAF Board, the PMA Managing Director and the PMA Legal Counsel) it is necessary to suspend Accreditation with immediate effect, as soon as reasonably possible after suspending Accreditation the CEO must:

(a) provide the Accredited Practitioner with written notice of issues of concern, including reasonable particulars, and the basis and terms of the proposed or actual suspension;

(b) provide the Accredited Practitioner with an opportunity to make a written submission in response to the concerns raised; and

(c) provide the Accredited Practitioner with a copy of these Facility Rules.

20.3 If the CEO suspends an Accredited Practitioner's Accreditation, he/she must immediately advise the Credentials Committee and PMAF Board. This suspension constitutes a consequential variation to the Accreditation of the Accredited Practitioner at all PMA Facilities at which Accreditation is held, unless otherwise determined and notified by the PMAF Board. The CEO must advise the Clinical Manager/Director of Nursing of all other PMA Facilities at which the Accredited Practitioner is Accredited, of the suspension and the grounds for that suspension. The CEO, after consultation with the Credentials Committee and PMAF Board of the other facility/facilities, the PMA Managing Director and the PMA Legal Counsel, suspend the Accredited Practitioner's Accreditation at their Facility in accordance with Rules 20.1 to 20.3.

21. TERMINATION OF ACCREDITATION

21.1 The PMAF Board may terminate the Accreditation of an Accredited Practitioner if:

(a) the Accredited Practitioner ceases to be registered in the relevant profession, specialty and jurisdiction to allow Treatment within the Scope of Practice for which Accreditation has been issued;

(b) the Accredited Practitioner fails to observe a General Condition or a Special Condition of Accreditation;

(c) The Accredited Practitioner makes a disclosure pursuant to the continuous disclosure requirements in Facility Rules 26.1 and 26.2 where, in light of the facts and circumstances disclosed, the PMAF Board considers continued Accreditation to be untenable;

(d) the Accredited Practitioner has been unable or unwilling to perform his/her patient care and Treatment duties for six (6) months out of the previous period of twelve (12) months;

(e) if the Accredited Practitioner is authorized to admit patients, he/she has not admitted any patients in six (6) months or more out of the previous period of twelve (12) months;

(f) the Accredited Practitioner is found guilty of professional misconduct and/or unsatisfactory professional conduct (howsoever termed) by any inquiry, investigation or hearing by any disciplinary body or professional standards organization;

(g) the Accredited Practitioner has been convicted or pleaded guilty to a criminal offence (excluding driving offences that do not result in a prison term) including a serious sex or violence offence or an offence involving dishonesty or drugs;

(h) the Accredited Practitioner has engaged in any conduct which in the reasonable opinion of the PMAF Board is likely to bring the Accredited Practitioner into professional disrepute;

(i) the Accredited Practitioner has engaged in any conduct which in the reasonable opinion of the Board is likely to harm the reputation of the relevant Facility or of PMA;

(j) the Accredited Practitioner does not have continuing confidence of the PMAF Board;

(k) the PMAF Board does not regard the Accredited Practitioner as having Current Fitness;

(l) the Facility ceases to provide support services required within the Scope of Clinical Practice of the Accredited Practitioner;

(m) in the opinion of the PMAF Board to do so would be in the interest of patient care or safety or in the interest of staff welfare or safety;

(n) in the reasonable opinion of the PMAF Board the conduct or continuing Accreditation of the Accredited Practitioner compromises the efficient operation or any interest of the Facility or of PMA;

(o) serious issues of concern to the PMAF Board (not otherwise falling within Rules 92.1 to 92.13) have been raised in relation to the Accredited Practitioner;

(p) the Accredited Practitioner has applied for a review of the suspension of his/her Accreditation under Rule 20 or 20.2 and on review the decision to suspend Accreditation is upheld, or

(q) the Accredited Practitioner fails to maintain, is refused professional indemnity insurance (for the cover required by these Rules) or a claim on the Accredited Practitioner's professional indemnity insurance is denied (whether or not such claim relates to Treatment provided to patients of a PMA facility or not).

21.2 As a separate right and notwithstanding anything in Rule 21.1, the PMAF Board may terminate the accreditation of an Accredited Practitioner without being required to provide reasons by providing no less than three (3) months written notice, or such other period as the Board considers reasonable in the circumstances.

21.3 The PMAF Board shall notify an Accredited Practitioner in writing of the termination of his/her Accreditation at any or all PMA Facilities, including the reasons for it (unless terminated under Rule 21.2), and shall forward a copy of the Facility Rules to the Accredited Practitioner with the written notification.

21.4 There shall be no right to seek a review of a decision of the PMAF Board to terminate Accreditation made under Rules 21.1(a) – 21.1(c), 21.1(f), 21.1(g), 21.1(l), 21.1(n), 21.1(q) or 21.2.

21.5 The termination of an Accredited Practitioner's Accreditation at one PMAF shall cause the automatic termination of Accreditation held at any other PMAF unless or to the extent otherwise determined by the PMAF Board. .

22. RIGHT OF REVIEW OF DECISION AFFECTING ACCREDITATION

22.1 Subject to Rules 13.17, 14.10, 21.4, 23.2 and 23.3 an Accredited Practitioner (applicant) may seek a review of a decision in relation to suspension, variation or termination of their Accreditation, including any variation to their authorized Scope of Clinical Practice, Accreditation Classification and/or conditions of Accreditation. A request for review must be lodged in writing with the CEO within fourteen (14) days of notification of the decision to vary, suspend or terminate

the Accreditation. The PMAF Board may in its absolute discretion, but is not obliged to, consider late applications for review.

22.2 The PMAF Board must establish a Review Committee to determine a request under Rule 22.1. The Review Committee must comprise:

(a) a nominee of the PMAF Board, whether such nominee is a standing appointment or specifically appointed to a particular Review Committee;

(b) the Director of Medical Services (if appointed) or an Accredited Practitioner in the same specialty field at the Facility who is not a member of the MAAC; and

(c) a nominee of the relevant professional college or, if there is no nomination or the nominee is unavailable, a specialist Medical Practitioner nominated by the PMAF Board who, if the review relates to clinical matters, must work in the same specialty field as the applicant.

22.3 The nominee of the PMAF Board shall be the chairperson of the Review Committee.

22.4 The applicant must be provided with appropriate notice by the Review Committee and be given the opportunity to make a submission to the Review Committee.

22.5 101. The chairperson of the Review Committee shall determine whether submission(s) shall be verbal and/or in writing. The Review Committee will request that any written submissions are provided within four (4) weeks of the Review Committee's request, or such other period agreed with the chairperson of the Review Committee.

22.6 Neither the applicant nor any other party to the review process has a right to be represented by a legal practitioner or any other person at a meeting of the Review Committee.

22.7 Subject to Rules 22.1 to 22.6, the chairperson of the Review Committee shall determine any question of procedure in relation to a review.

22.8 The Review Committee shall make a written recommendation to the PMAF Board. The PMAF Board shall then make a decision which will be binding on the parties involved in the review.

22.9 The CEO shall notify the applicant in writing of the PMAF Board's decision as soon as reasonably possible after receiving the PMAF Board's advice, and implement the decision immediately.

23. CONTRACTED PROVIDERS

23.1 If a contract provides for the delivery of clinical services (such as medical imaging or pathology) by a third party contractor to the patients of the Facility, the contract may:

(a) provide that only Medical Practitioners and Dentists who have been Accredited to Treat patients at the Facility may provide the clinical services; or

(b) require the third party contractor to ensure that:

(1) the Credentials and professional indemnity insurance status of the Medical Practitioners and Dentists who provide the contracted services are verified by the third party contractor in accordance with all PMAF policy notified to the third party, are consistent with the contractual requirements with PMA, and that evidence of Credentials and professional indemnity insurance are provided to the CEO of the Facility before any contracted services are provided; and

(2) the Medical Practitioners and Dentists who provide the services do so only within the Scope of Clinical Practice or under the Accreditation Classification or conditions of Accreditation specified in the contract as generally applicable to all Medical Practitioners or Dentists providing the services, unless they have been Accredited specifically by the Facility as Accredited Practitioners with a modified Scope of Clinical Practice, Accreditation Classification and/or conditions of Accreditation.

23.2 A contract for the delivery of a clinical service by a third party contractor to the patients of the Facility must enable the CEO to withdraw authority for any Medical Practitioner or Dentist to provide all or some of the contracted services to Patients of the Facility. There shall be no right of review against a decision made pursuant to this Rule.

23.3 The Accreditation of a Medical Practitioner or Dentist who provides services on behalf of a third party contractor to the patients of the Facility shall terminate with the contract pursuant to which those services are provided. There shall be no right of review against the termination of an Accreditation pursuant to this Rule.

24. ACCREDITATION OF ALLIED HEALTH PROFESSIONALS, NURSE FIRST ASSISTANTS AND NURSE PRACTITIONERS

24.1 **Accreditation subject to registration and adequate insurance**

Prior to the Accreditation of an Allied Health Professional, Nurse First Assistant or Nurse Practitioner pursuant to these Facility Rules:

(a) where a relevant registration process applies, the CEO shall ensure that the applicant is registered according to statutory requirements; and

(b) the CEO shall ensure that the professional indemnity insurance held by the applicant is adequate and in accordance with PMA policies.

24.2 **The Accreditation process**

The provision of Rules 13 to18 inclusive and or Rules 23 inclusive (as applicable) shall apply to the Accreditation of Allied Health Professionals, Nurse First Assistants and Nurse Practitioners (to the extent possible) with the words:

(a) "Accredited Allied Health Professional" or "Accredited Nurse First Assistant" or "Accredited Nurse Practitioner", as appropriate, being deemed to apply where the term "Accredited Practitioner" is stated therein; and

(b) "Allied Health Professional" or "Nurse First Assistant" or "Nurse Practitioner", as appropriate, being deemed to apply where the term "Medical Practitioner" or "Dentist" is stated therein.

24.3 **Review of Accreditation**

The CEO may at any time, taking into account such advice as he or she deems necessary to assist in decision-making, review, suspend, terminate, and/or change the conditions associated with, the Accreditation of an Allied Health Professional, Nurse First Assistant or Nurse Practitioner.

24.4 **No right of review**

There shall be no right to seek a review of a decision concerning the Accreditation, re-Accreditation or Scope of Clinical Practice of Allied Health Professionals, Nurse First Assistants or Nurse Practitioners, including a decision to change an authorized Scope of Clinical Practice, suspend or terminate Accreditation or change any other conditions associated with Accreditation.

25. ISSUES OF CONCERN RAISED ABOUT ACCREDITED HEALTH PROFESSIONALS

25.1 The CEO of the Facility may make inquiries regarding concerns raised in relation to an Accredited Health Professional if the CEO considers that any of the following consequences may occur:

(a) patient health or safety could be compromised;

(b) the efficient operation of the Facility could be hindered;

(c) the reputation of the Facility or of PMA could be threatened;

(d) the interest of a patient or someone engaged in or at the Facility could be affected adversely; or

(e) a law may be, or has been, contravened.

25.2 The CEO shall advise the Accredited Health Professional in respect of whom the concern has been raised, and may do so in the presence of the chairperson of the MAAC or his/her authorised delegate, of the substance of the concern and provide the Accredited Health Professional with an opportunity to respond.

25.3 If, having considered the Accredited Health Professional's response (if any), then:

(a) the CEO shall advise the MAAC of the substance of any serious concern and the steps proposed to resolve it;

(b) if in the opinion of the CEO the matter can be dealt with appropriately by reviewing the Accredited Health Professional's Scope of Clinical Practice, Accreditation Classification or conditions of Accreditation, the CEO may request a review in accordance with Rules 19.1 to 19.7;

(c) if in the opinion of the CEO the matter cannot be dealt with appropriately by a review of the Accredited Health Professional's Scope of Clinical Practice, the CEO in consultation with the chairperson of the MAAC may establish a Review Committee to consider the matter further; and/or

(d) the CEO may suspend or impose conditions on the Accreditation, including the Scope of Clinical Practice, of the Accredited Health Professional until such time as the CEO is satisfied that the concern has been resolved or will be by the proposed suspension of Accreditation or imposition of conditions.

25.4 A Review Committee established under Rule 25.3(c):

(a) must ensure that the Accredited Health Professional has been advised in writing of the particulars of the concern and invited the Accredited Health Professional to respond in writing;

(b) may invite the Accredited Health Professional to meet with the committee in person; and

(c) must provide the CEO with its written conclusions and/or opinions supported by reasons.

25.5 Following consideration of the Review Committee's advice, the CEO:

(a) shall advise the PMAF Board, through the MAAC, of any action he or she considers necessary to address the concerns, including terminating or suspending the Accreditation of, or imposing conditions on, the Accredited Health Professional's Accreditation; and

(b) shall advise the Accredited Health Professional of the PMAF Board's decision as soon as reasonably possible after receiving the PMAF Board's advice, and implement the decision immediately.

26. CONTINUOUS DISCLOSURE

26.1 Every Accredited Health Professional must keep the CEO of the Facility continuously informed of matters which have a material bearing upon:

(a) the Credentials and in particular the registration of the Health Professional (if applicable);

(b) the Scope of Clinical Practice of the Health Professional;

(c) the ability of the Health Professional to deliver health care services to patients safely within his/her authorized Scope of Clinical practice; and

(d) the Health Professional's professional indemnity insurance status.

26.2 Without limiting the scope of the obligations described in Rule 26.1, an Accredited Health Professional must provide the CEO of the Facility with evidence of his/her current registration and insurance at least annually and must advise the CEO in writing immediately if any of the following occur:

(a) He/she ceases to be registered or is suspended from registration under the relevant professional registration laws;

(b) any conditions, limitations or restrictions are imposed by a registration board in relation to his/her practice;

(c) an investigation is initiated in respect of his/her practice by any registration, disciplinary, investigative or professional body;

(d) an adverse finding is made against him/her by any registration, disciplinary, investigative or professional body;

(e) his/her appointment to, accreditation at or scope of clinical practice at, any other facility, hospital or day procedure centre is altered in any way;

(f) any other Facility or non-PMAF imposes conditions or restrictions of any kind or makes any written recommendations regarding the Accredited Health Professional;

(g) he/she incurs an illness or disability which may adversely affect his/her Current Fitness;

(h) he/she is charged with or convicted or any indictable criminal offence or breach of any laws that regulate the provision of health care or health insurance; or

(i) he/she ceases to hold professional indemnity insurance in accordance with PMA policy and standards or has his/her professional indemnity insurance made conditional or not renewed.

27. RESEARCH AND THE INTRODUCTION OF NEW CLINICAL SERVICES, PROCEDURES AND OTHER INTERVENTIONS

27.1 **Research**

(a) Any research, including clinical trials, involving human subjects that is proposed to be conducted in or at the Facility shall only commence if:

(1) a nominated member of the staff of the Facility or an Accredited Practitioner or Accredited Allied Health Practitioner will be accountable for the conduct of the research;

(2) the CEO, with the advice of the PMA Legal Counsel, is satisfied that appropriate indemnity and/or insurance arrangements are in place;

(3) it has been approved by an appropriately constituted Ethics Committee in accordance with National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (**the National Statement**) and it shall be conducted in accordance with any approvals provided by that committee; and

(4) it has been approved by the CEO and the MAAC in accordance with PMA policy.

(b) If the proposed Research involves patients at the Facility by an Accredited Health Professional, it shall not commence unless the Research is consistent with the Scope of Clinical Practice, Accreditation Classification and/or conditions of Accreditation of the relevant Health Professional granted in accordance with these Facility Rules.

(c) If there is doubt about whether a proposed activity constitutes Research or quality assurance or some other activity, the CEO with advice from the MAAC and the PMA Legal Counsel, shall make a determination about the nature of the activity.

(d) The CEO or his/her authorized delegate may withdraw permission for, or place conditions upon, the conduct or continuation of Research involving human subjects at the Facility if in his/her opinion the Research:

(1) cannot be conducted by the Accredited Health Professional and/or supported by the Facility at an appropriate standard of safety and quality;

(2) is outside the authorized Scope of Clinical Practice, Accreditation Classification and/or conditions of Accreditation of the Accredited Health Professional;

(A) is likely to result in damage to the Facility and/or PMA's reputation;

(B) represents a significant risk to the health and safety of any person; or

(C) if any insurance or indemnities provided in respect of the Research have expired, been revoked or are/become inadequate.

27.2 **Introduction of New Clinical Services, Procedures or Other Interventions**

(a) An Accredited Practitioner who proposes to perform a New Clinical Service, Procedure or Other Intervention must apply to the CEO for approval of the New Clinical Service, Procedure or Other Intervention.

(b) The CEO shall refer the application to the MAAC which shall advise on the safety, efficacy and role of the New Clinical Service, Procedure or Other Intervention in the context of the Facility's needs and capability.

(c) The MAAC shall advise the CEO:

(1) whether, and under what conditions, the New Clinical Service, Procedure or Other Intervention could be introduced safely to the Facility; and

(2) whether the New Clinical Service, Procedure or Other Intervention is consistent with the Accredited Practitioner's Scope of Clinical Practice.

(d) The CEO may seek additional advice from the MAAC or any other person the CEO deems appropriate about the financial, operational or clinical implications of the introduction of the New Clinical Service, Procedure or Other Intervention.

(e) The CEO may refuse permission for the introduction of a New Clinical Service, Procedure or Other Intervention.

(f) Before approving the introduction of a New Clinical Service, Procedure or Other Intervention the CEO must:

(1) be satisfied that the New Clinical Service, Procedure or Other Intervention is consistent with the capability, recurrent operating plan and long-term strategic directions of the Facility:

(2) where the New Clinical Service, Procedure or Other Intervention involves Research, be satisfied that the requirements of Rules 27.1(a) to 27.1(b) have been met;

(3) be satisfied that the appropriate indemnity and/or insurance arrangements are in place; and

(4) notify the MAAC and PMAF Board of his/her determination.

28. PRIVACY AND CONFIDENTIALITY

28.1 **Privacy**

Accredited Health Professionals shall manage, and assist the Facility to manage, all matters related to the privacy of information in compliance with the Australian Privacy Principles established by the *Privacy Act 1988* (Cth) and in compliance with the various statutes governing the privacy of health information within different State and Territory jurisdictions.

28.2 **Confidential information**

Subject to Rule 28.1, every Accredited Health Professional must keep confidential the following information:

(a) business information concerning PMA or the Facility;

(b) information concerning the insurance arrangements of PMA or the Facility;

(c) all matters relating to Accreditation, including designation of Scope of Clinical practice of the Health Professional; and

(d) information concerning any patient of PMA Facilities.

28.3 **Committees**

All information made available to or disclosed in the context of a committee or sub-committee of the Facility shall be kept confidential unless the information is of a general kind and disclosure outside the committee or sub-committee is authorized specifically by the committee or sub-committee.

28.4 **What confidentiality means**

The confidentiality requirements of Rules 28.1 and 28.3 prohibit the recipient of such confidential information from using or disclosing it for any purpose, unauthorized or not, copying, reproducing or making it public.

28.5 **When confidentiality can be breached**

The confidentiality requirements of Rules 28.1 and 28.3 do not apply in the following circumstances:

(a) where disclosure is required or specifically authorized by law;

(b) where use and/or disclosure of personal information is consistent with Rule 28.1;

(c) where disclosure is required by a regulatory body in connection with the Health Professional, the Facility or PMA;

(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 a requirement of these Facility Rules.

PMA must be notified before (or as soon as practical after) any information is disclosed under this Rule 28.5 and the person disclosing must ensure that the recipient is aware of the confidential nature of the information and is required to keep such information confidential except for the purposes for which it was provided.

28.6 **Privacy and confidentiality obligations continue**

The privacy and confidentiality requirements of these Facility Rules continue with full force and effect after the Health Professional ceases to be Accredited at any Facility.

29. MEDICAL COUNCIL

29.1 **Composition**

(a) The Medical Council may be instituted by the CEO at his/her discretion at any of the PMA Facilities. The Medical Council is currently not instituted across all PMA Facilities with the MAAC undertaking its objectives.

(b) All Accredited Health Practitioners (except Surgical Assistants, Career Medical Officers, Registrars and Fellow Practitioners) and the Director of Medical Services (where one has been appointed) of the Facility shall be members of the Medical Council of the Facility.

29.2 **Objective**

(a) The Medical Council shall provide a forum for communication between the PMAF Board, the MAAC and Accredited Practitioners to facilitate the safe provision of patient care.

(b) The Medical Council shall nominate members for appointment to the MAAC and to Facility committees as required.

29.3 **Chairperson and deputy chairperson**

(a) At each Annual General meeting, or alternatively at the absolute discretion of the CEO at first meeting of the MAAC held after the Annual General Meeting, the Medical Council shall elect a chairperson and deputy chairperson who shall hold office until the next succeeding Annual General meeting. The chairperson and deputy chairperson, together with the Director of Medical Services if one has been appointed, shall be known jointly as the Medical Executive.

(b) The chairperson of the Medical Council, who must also act as chairperson of the MAAC, shall:

(1) assist with effective communication and representation of the opinions, policies, reports, concerns and needs of the Accredited Practitioners to the Facility;

(2) preside at, and be responsible for, the agenda of all meetings of the Medical Council and the MAAC; and

(3) facilitate the MAAC reviewing and confirming the support of Accredited Health Professionals for policies or Facility Rules of the Facility as they affect Accredited Health Professionals .

(c) The deputy chairperson of the Medical Council shall perform such duties as may be assigned to him or her by the Medical Council and the MAAC as the case may be.

(d) Should a vacancy occur in the position of chairperson or deputy chairperson of the Medical Council, it shall be filled by an Accredited Practitioner appointed by the MAAC from amongst its members until the next ordinary meeting of the Medical Council, at which a replacement shall be elected by the members of the Medical Council.

(e) No person shall hold office as the chairperson of the Medical Council for a period exceeding four (4) consecutive years unless approved in writing by the CEO or his/her authorised delegate.

(f) No office bearer or member of the Medical Council is entitled to represent that they individually or collectively represent PMA or the Facility, other than with the written permission of the CEO. The marks, logos and symbols of PMA and its Facilities may only be used for purposes authorized by the CEO.

29.4 **Ordinary and special meetings**

(a) Ordinary meetings of the Medical Council shall be held as required. The meetings shall be held at a time and place determined by the Medical Executive in conjunction with the CEO provided that at least fourteen (14) days' written notice of the meeting is given to members of the Medical Council specifying the business to be transacted.

(b) A special meeting of the Medical Council may be called by the chairperson of the Medical Council subject to the approval by the CEO. At least seven (7) days notice of a special meeting shall be given in writing to all members of the Medical Council entitled to attend such a meeting and specifying the business to be transacted at that meeting.

(c) The quorum of the Medical Council for all purposes shall be the number of the active members of the Medical Council, as defined in Rule 29.6, present in person at an ordinary or special meeting and as determined by the Medical Executive from time to time, taking into consideration the size of the Medical Council, provided that the quorum shall comprise no less than three (3) of the active members of the Medical Council present in person at an ordinary or special meeting.

29.5 **Annual General Meeting**

(a) An Annual General Meeting of the Medical Council shall be held once in every calendar year and not more than fifteen (15) months after the preceding Annual General meeting.

(b) Written notice of the Annual General meeting of the Medical Council, together with a copy of the agenda for that meeting, shall be given not less than fourteen (14) days prior to the date of the meeting.

29.6 **Proceedings at meetings**

(a) Only those Accredited Practitioners who are in attendance at a meeting of the Medical Council are entitled to vote. There shall be no proxy vote.

(b) Only active members of the Medical Council shall be eligible to vote and stand for office of the Medical Council, MAAC or any other office bearer or committee position. An active member of the Medical Council means an Accredited Practitioner (other than a Surgical Assistant, Consultant Emeritus, Career Medical Officer or Fellow Practitioner) who utilizes

the Facility on a regular basis as determined by the CEO on the basis of an assessment of activity over the prior six (6) month period (taking into account normal conference, holiday and sick leave).

Utilisation of the Facility on a regular basis means:

(1) for an anaesthetist or proceduralist, utlising a regularly allocated operating list at least monthly; or

(2) for a physician or General practitioner, an average of least one Facility admission per fortnight; or

(3) other work, attendance or reporting on a regular active basis each fortnight; or

(4) participation in the Facility-administered roster for the day-to-day delivery of care; or

(5) undertaking teaching or other approved activity such as Research on a regular basis for or on behalf of the Facility.

(c) All questions shall be decided by a show of hands or, where demanded by a member entitled to vote, by a secret ballot.

(d) The chairperson of the Medical Council shall have a deliberative vote and, where there is an equality of votes, a casting vote.

(e) Minutes of all meetings of the Medical Council shall be recorded by the CEO or his/her authorized delegate and distributed to all those entitled to attend meetings of the Medical Council prior to the next meeting.

(f) No business shall be considered at a meeting of the Medical Council until the minutes of the previous meeting have been confirmed or otherwise disposed of.

(g) Minutes of a meeting shall be confirmed by resolution and signed by the chairperson at the next meeting and minutes so confirmed and signed shall be taken as evidence of those proceedings.

29.7 **Nomination of members to the Medical Advisory & Audit Committee**

(a) At each annual general meeting, the Medical Council shall nominate from amongst its members at least five (5) Accredited Practitioners, or any other number required by law, for appointment by the CEO as members of the MAAC.

(b) The Medical Council's nominations for membership of the MAAC must include (where available):

(1) if the CEO has established Clinical Departments in accordance with Rule 5, the head of each such Clinical Department;

(2) if Anaesthetic services are provided at the Facility, at least one Accredited Practitioner who is an Anaesthetist; and

(3) at least one Accredited Practitioner from any other major specialty group of the Facility as determined by the Medical Executive, the CEO and as required by law.

(c) An Accredited Practitioner from a major specialty group from which nominations are sought may nominate himself or herself or another Accredited Practitioner for membership of the MAAC. If only one Accredited Practitioner from a major specialty group from which nominations are sought is nominated, the Medical Council may accept that nomination for appointment to the MAAC. In the event that two (2) or more Accredited Practitioners are nominated from a major specialty group from which nominations are sought, the Medical Council shall hold a ballot of its members to determine which candidate it shall nominate for appointment to the MAAC. Any dispute regarding the procedure or results of any ballot held under this Rule shall be determined by the PMAF Board in accordance with Rule 4.

30. MEDICAL ADVISORY & AUDIT COMMITTEE

30.1 **Establishment and composition**

(a) The CEO shall establish and maintain a MAAC comprising:

(1) the CEO, PMA Managing Director, Medical Executive (if applicable) and the Clinical Manager/Director of Nursing; and

(2) those persons nominated by the PMAF Board and/or the Medical Council (if applicable) in accordance with Rules 29.3(a) and 29.7.

(b) The MAAC must, wherever possible, include at least one person from those major specialty groups of the Facility as determined by the PMAF Board and/or Medical Executive (if applicable) and the CEO and as required by law.

(c) At least five (5) of the persons appointed to the MAAC must be Accredited Practitioners.

(d) A MAAC may co-opt the services of any other person (including persons who are not Accredited Practitioners) whether for a specific time or generally, as it sees fit. A person co-opted to assist a MAAC has not voting rights.

30.2 **Term of appointment and resignation of members**

(a) The members of the MAAC nominated by the PMAF Board and/or Medical Council (if applicable) have a term of appointment of five (5) years commencing from the end of their first meeting attendance or the Annual General meeting of the Medical Council at which they are nominated.

(b) Any member of the MAAC nominated by the PMAF Board and/or Medical Council (if applicable) who has served on the MAAC for three (3) consecutive terms is ineligible to be appointed to the MAAC for the immediately succeeding term unless the appointment is approved in writing by the CEO.

(c) Any Accredited Practitioner who is a member of a MAAC may resign from the position with one month's prior written notice to the CEO and/or the Medical Council (if applicable).

(d) Any member of the MAAC whose Accreditation expires or is terminated or suspended will automatically cease to be a member of the MAAC from the date of expiration, termination or suspension.

(e) Where restrictions are placed on the right of any member of the MAAC to practice medicine by a Medical Board, Department of Health or other competent authority or if in the reasonable opinion of the CEO a member of the MAAC has a significant conflict of interest (whether actual, perceived or potential) with the interests of the Facility or of PMA, the CEO, having consulted with the PMA Managing Director, the chairperson of the MAAC and the PMAF Board, will determine if it is in the best interest of the Facility to require the MAAC member to step down from his/her position on the MAAC. The CEO will communicate any decisions, including whether membership is suspended or terminated for any period or on any conditions, to the MAAC and PMAF Board and to the member by providing notice in writing which will have immediate effect.

(f) If a member of the MAAC resigns or ceases to be a member of the MAAC under Rules 30.2(a) to 30.2(e), the PMAF Board and/or Medical Council (if applicable) shall nominate a replacement member in accordance with the procedure described in Rules 29.7.

30.3 **Roles**

(a) The MAAC is an advisory committee to the CEO. The roles of the MAAC are:

(1) to be the formal organizational structure through which the views of the Accredited Practitioners of the Facility are formulated and communicated;

(2) to provide a means whereby Accredited Practitioners can participate in the policy-making and planning processes of the Facility;

(3) to plan and manage a continuing education program for members of the Medical Council (if applicable) or junior medical staff where appropriate;

(4) to advise the CEO on the clinical organization of the Facility;

(5) to assist in identifying health needs of the community and to advise the CEO on services that may be required to meet those needs;

(6) to participate in the planning and implementation of quality programs;

(7) to endeavour to ensure that the level of patient care provided by the Facility is optimized given local resources;

(8) to ensure that a process for review of clinical outcomes and patient management is established and executed according to these Facility Rules;

(9) to perform the functions of the Credentials Committee if a separate committee is not established and advise in relation to:

(A) applications for Accreditation and re-accreditation of Health Professionals in accordance with these Facility Rules;

(B) the Scope of Clinical Practice of applicants recommended for Accreditation or re-Accreditation;

(C) the Scope of Clinical Practice of Accredited Practitioners whose Scope of Clinical Practice has been subject to review; and

(D) applications for the introduction of New Clinical Services, Procedures and Other Interventions;

and in each case make recommendations to the CEO;

(10) to establish a Clinical Review Committee in accordance with Rule 32.1; and

(11) to fulfil the role of the Medical Council if such council is not separately established. .

(b) The CEO and/or each Clinical Department (if applicable) shall provide a report or minutes of its meetings to the MAAC on a regular basis.

(c) No member of a MAAC is entitled to represent that individually or collectively they represent PMA or the Facility, other than with the written permission of the CEO. The marks, logos and symbols of PMA and its Facilities may only be used for purposes authorized by the CEO.

30.4 **Meetings**

(a) Ordinary meetings of the MAAC must be held not less than two (2) times per year at a time and place determined by the chairperson of the MAAC in consultation with the CEO, provided that at least fourteen (14) days notice must be given of every ordinary meeting.

(b) A special meeting of the MAAC may be called by the chairperson of the MAAC at any time subject to the approval of the CEO. The members of the MAAC must be given at least seven (7) days notice of a special meeting or such shorter period as may be necessary in the circumstances and consented to by the members of the MAAC.

(c) Notice of a meeting must specify the business to be considered; and in the absence of unanimous agreement of the members of the MAAC to the contrary, no other business will be considered.

(d) In an emergency, the CEO may act without advice from the MAAC in circumstances where that advice ordinarily would be required. The MAAC must consider the issue at a subsequent meeting.

30.5 **Proceedings at meetings**

(a) Members of the MAAC other than the PMA Managing Director, CEO and the Clinical Manager/Director of Nursing are entitled to vote at its meetings.

(b) All questions shall be decided by a show of hands. The chairperson shall conduct a secret ballot where at least one of the members of the MAAC requests it.

(c) The chairperson of the MAAC shall have a deliberative vote and, where there is an equality of votes, a casting vote.

(d) The CEO or delegate shall record minutes of all meetings of the MAAC. Those minutes shall be distributed to the members of the MAAC prior to their next meeting.

(e) The MAAC shall not proceed to discuss new business until it has considered and dealt with the accuracy of the minutes for the immediately preceding meeting. Consideration of previous minutes is limited to their accuracy.

(f) if a meeting of the MAAC resolves that the minutes of a preceding meeting are accurate, the chairperson shall sign a copy of them. The chairperson's signature is evidence of their accuracy.

30.6 **Terms of reference**

The CEO shall develop terms of reference for the MAAC that accord with relevant regulatory requirements.

31. CREDENTIALS COMMITTEE (FUNCTIONS PERFORMED BY MAAC)

31.1 **Establishment and composition**

(a) The CEO shall establish a Credentials Committee unless the MAAC assumes the responsibilities of the Credentials Committee in accordance with Rules 31.1(f). In all PMA Facilities, the MAAC performs the functions of the Credentials Committee.

(b) Membership of the Credentials Committee shall comprise:

(1) the Medical Executive (if applicable);

(2) at least one nominee of each of the Clinical Departments of anaesthetics, medicine and surgery (if such Clinical Departments have been established or if not at least three (3) Accredited Practitioners nominated annually by the Medical Council) who must be and remain Accredited at the Facility; and

(3) a nominee (who must be and remain Accredited at the Facility) of the head of the Clinical Department relevant to the application(s) for Accreditation, where such Clinical Departments or Services have been established; or

(4) if a Clinical Department has not been established, an Accredited Practitioner in the relevant specialty; or

(5) if there are no Accredited Practitioners in the relevant specialty, a Medical Practitioner or Dentist who practices in that specialty nominated by the relevant professional body; or

(6) if there is no suitable nomination by the relevant professional body, a Medical Practitioner or Dentist practicing in the relevant specialty appointed by the CEO.

(c) Where restrictions are placed on the right of any member of the Credentials Committee to practice medicine by a Medical Board, Department of Health or other competent authority or if in the reasonable opinion of the CEO a member of the Credentials Committee has a significant conflict of interest (whether actual, perceived or potential) with the interests of the Facility or of PMA, the CEO, having consulted with the PMAF Board and the MAAC, will determine if it is in the best interest of the Facility to require the member to step down from

his/her position on the Credentials Committee. The CEO will communicate any decisions, including whether membership is suspended or terminated for any period or on any conditions, to the MAAC, PMAF Board and to the member by providing notice in writing which will have immediate effect.

(d) The chairperson of the Credentials Committee shall be elected for an annual term by the Accredited Practitioner members of the committee.

(e) The CEO, Director of Medical Services (if applicable) and Clinical Manager/Director of Nursing may attend meetings of the Credentials Committee but shall not have the right to vote at such meetings.

(f) Except where required by law to establish a separate Credentials Committee, the CEO may, in consultation with the MAAC, elect not to establish a Credentials Committee, in which case the MAAC will undertake the responsibilities of the Credentials Committee as defined in these Facility Rules.

31.2 **Roles and processes**

(a) The Credentials committee is an advisory committee to the MAAC.

(b) The role of the Credentials Committee shall be to:

(1) ensure that each of its members is aware of their obligations to act fairly and without bias and to avoid conflicts of interest;

(2) advise the CEO through the MAAC on the application or PMA's policies for verification of Credentials of applicants for Accreditation or re-Accreditation or when considering a request for a review of Scope of Clinical Practice of an Accredited Practitioner;

(3) develop criteria for and plan and monitor the effectiveness of a program for the delineation of Scope of Clinical Practice of Medical practitioners and Dentists, where required by the Board;

(4) consider, in relation to every application referred to it for Accreditation or for review of an Accredited Practitioner's Scope of Clinical practice:

(A) the Credentials, qualifications, experience, professional standing and other relevant professional attributes of each Health Professional for the purposes of forming a view about their competence, performance, Current Fitness,

character of and confidence held in the applicant and professional suitability; and

(B) the needs and capabilities of the Facility;

and make recommendations to the CEO on Accreditation or re-Accreditation and the appropriate Scope of Clinical practice for each applicant;

(5) consider applications by Accredited Practitioners for review of their authorized Scope of Clinical Practice and make recommendations to the CEO;

(6) if requested by any of the CEO, the Clinical Manager/Director of Nursing, the Director of Medical Services (if applicable), the chairperson of the Medical Council (if applicable), the head of the Clinical Department in which an Accredited Practitioner practices (if applicable) , the PMAF Board, to review the current Scope of Clinical Practice of the Accredited Practitioner and, following due consideration and taking into account the Credentials, qualifications, experience, competence, professional performance, Current Fitness, professional suitability of and confidence held in the Accredited Practitioner and the needs and capabilities of the Facility, make recommendations concerning amendment or revocation of the Accredited Practitioner's Cope of Clinical Practice and/or Accreditation to the Facility.

(c) In undertaking its responsibilities, the Credentials Committee must take account of the following:

(1) whether, and to what extent, the Credentials, qualifications, experience, skills and training of each applicant for Accreditation support the Classification of Accreditation and Scope of Clinical Practice sought by the applicant;

(2) the character and standing of each applicant, and whether each applicant is a suitable person to practice at that Facility;

(3) whether the Facility can support the Scope of Clinical Practice proposed by each applicant; and

(4) whether in its opinion each applicant will continue to observe the current policies and processes of the Facility.

(d) The Credentials Committee may request any applicant for Accreditation or Re-Accreditation or any Accredited Practitioner whose Scope of Clinical Practice is under review to provide evidence within a reasonable period of time of any aspect of their qualifications, experience, competence, professional performance, Current Fitness and professional suitability and/or

to submit written material in support of their requested Scope of Clinical Practice and/or to present in person to the Committee.

(e) The Credentials Committee may recommend conditions on the Scope of Clinical Practice of any applicant for Accreditation or Re-Accreditation or any Accredited Practitioner whose Scope of Clinical practice is under review, including, without limitation, requirements for participation in a formal mentoring and/or supervision program, requirements for monitoring and/or review of performance and requirements for procedural throughput within a designated period.

31.3 **Meetings and proceedings**

(a) The requirements for meetings and proceedings for the Credentials Committee shall be the same as those provided for the MAAC in Rules 30.4 to 30.6.

(b) The Credentials Committee shall be provided with appropriate administrative support by the Facility.

32. CLINICAL REVIEW COMMITTEE (FUNCTIONS PERFORMED BY THE MAAC)

32.1 **Establishment and composition**

(a) The MAAC shall establish a Clinical Review Committee unless the MAAC assumes the responsibilities of the Clinical Review Committee in accordance with Rule 32.1(d). In all PMA Facilities, the MAAC performs the functions of the Clinical Review Committee comprising:

(1) in the case of the Facility where Clinical Departments or Services are established, one nominee from each of the Clinical Departments or Services who must be and remain Accredited at the Facility; or

(2) where Clinical Departments of Services are not established, a nominee from each major specialty group who must be and remain Accredited at the Facility; and

(3) the CEO, Clinical Manager/Director of Nursing and Director of Medical Services (where appointed) or their delegate.

(b) Other relevant persons may be co-opted as determined by the Review Committee.

(c) The chairperson of the Clinical Review Committee shall be an Accredited Practitioner member of the Review Committee, elected for an annual term by the members of the committee..

(d) As an alternative to creating a separate Clinical Review Committee, the MAAC may assume the responsibilities of the Clinical Review Committee provided an appropriate mix of specialties is represented on the MAAC or can be achieved through co-opting relevant persons.

32.2 **Role**

(a) The Clinical Review Committee shall:

(b) be responsible for clinical leadership of safety and quality at the Facility;

(c) develop and oversee the implementation of an adequate clinical review and quality improvement program in liaison with Clinical Departments or Services for each twelve (12) month period;

(d) monitor the clinical review and quality improvement activities of the Facility and advise the CEO of their adequacy and compliance with applicable statutory requirements;

(e) review reports from the Clinical Departments or Services (where in existence), on clinical review and quality improvement activities undertaken;

(f) review the action taken by the Clinical Departments of Services (where in existence), regarding the clinical review and quality assurance activities;

(g) review the results of the clinical indicator program and advise the CEO of the appropriate action to be taken in respect of these results; and

(h) advise the CEO of actions that need to be taken to assure and improve effective clinical review and quality improvement activities and programs at the Facility. Meetings

32.3 **Meetings**

(a) Meetings of the Clinical Review Committee shall be held no less than two (2) times per year.

(b) Minutes of all meetings of the Clinical Review Committee shall be recorded by the CEO or delegate.

(c) Minutes shall be submitted to the MAAC and also distributed to all those entitled to attend meetings of the Clinical Review Committee prior to the next meeting.

(d) No business shall be considered at a meeting of the Clinical Review Committee until the minutes of the previous meeting have been confirmed or otherwise disposed of.

(e) Minutes of a meeting shall be confirmed by resolution and signed by the chairperson at the next meeting and minutes so confirmed and signed shall be taken as evidence of proceedings thereat.

32.4 **Clinical Review Committee (tertiary hospital)**

(a) A Facility that operates in a tertiary hospital environment may organize clinical review through the Clinical Departments of Services as a substitute for a separate Clinical Review Committee if it can be demonstrated to the satisfaction of the CEO that such processes meet the minimum requirements of the Clinical Review Committee set out in Rules 32.1(a) and 32.2 and incorporate appropriate reporting to the MAAC and the CEO.

(b) The Clinical Departments of Services shall provide to the MAAC such reports and information as are required from time to time.

33. GENERAL PROVISIONS APPLYING TO COMMITTEES

33.1 **Conflict of interests**

(a) If a member of any committee established under these Facility Rules or any person authorized to attend any committee meeting has a direct or indirect pecuniary interest, a conflict or potential conflict of interest or a direct or indirect material personal interest:

(1) in a matter that has been considered or is about to be considered at a meeting, such a member or person shall, subject to rules 33.1(f) and 33.1(g), not participate in the relevant discussion or resolution of any such interest or matter nor shall such a person be eligible to hold any office whilst any such interest exists;

(2) in a thing being done or about to be done by the Facility; or

(3) that is in conflict with the interests of the Facility or of PMA, such a member or person shall as soon as possible after the relevant facts have come to the person's knowledge, disclose the nature of the interest at the meeting.

(b) A disclosure by a person at a meeting of the committee that the person:

(1) is a director or member or is in the employment of, or is a consultant to, a specified company or other body;

(2) is a partner, or is in the employment, of a specified person, or

(3) has some other specified interest (including a pecuniary or personal interest, whether direct or indirect) relating to a specified company or other body or a specified person;

shall be deemed to be a sufficient disclosure of the nature of the interest, in any matter or thing relating to that company or other body or to that person, which may arise after the date of the disclosure.

(c) A person who holds shares in PMA shall not be regarded as having a conflict of interest.

(d) The committee shall cause particulars of any disclosure made under Rules 33.1(a) or 33.1(b) to be recorded and declared by the member or authorized person in writing on a pecuniary interest/conflict of interest/material interest declaration form.

(e) The chairperson of the committee shall advise the CEO of any disclosure made pursuant to these Facility Rules.

(f) The CEO, after consultation with the chairperson of the committee, shall make a determination in relation to the disclosure of an interest pursuant to this Rule. Such determination may, but is not limited to, include making a determination that the member or person may not vote, will not participate in the meeting when the matter is being considered or that the member or person will not be present while the matter is being considered at the meeting.

(g) The CEO may, at his/her discretion, refuse entry to a committee meeting to any person that the CEO believes on reasonable grounds has conflict of interest within the meaning of Rule 33.1, whether or not that conflict of interest has been disclosed.

(h) Subject to Rule 33.1(b), the fact that a member of the MAAC is a member of a particular discipline shall not be regarded as creating a direct or indirect pecuniary interest, a conflict or potential conflict of interest or a direct or indirect material personal interest if that committee member participates in the Accreditation of a Health Professional in the same discipline.

33.2 **Statutory immunity for committees**

Statutory immunity (otherwise referred to as qualified privilege) approval under the relevant State or Federal legislation may only be sought for the MAAC (performing the functions of the Clinical Review Committee) or a quality activity with the prior approval of the PMA CEO who shall consider the advice of the PMAF Board. No committee or sub committee of the Facility shall seek any such statutory immunity or approval without the prior approval of the PMA CEO.

SCHEDULE 1
GENERAL CONDITIONS OF ACCREDITATION

Accredited Health Professionals must:

(1) comply with the provisions of the Act, these Facility Rules, policies and procedures established by the Facility from time to time and any reasonable directions of the CEO;

(2) comply with codes of conduct and/or codes of behavior adopted by the Facility and/or PMA from time to time, which at a minimum includes acting professionally and courteously toward Facility staff and contractors, other Accredited Health Professionals and all other persons on the premises of a Facility;

(3) comply with their authorized Scope of Clinical Practice;

(4) maintain their professional registration with the relevant registration board, and furnish annually to the Facility documentary evidence of registration under the registration act for medical practitioners or health professionals in the State and advise the CEO immediately of any material changes to the conditions or status of their professional registration including suspension or termination;

(5) attend patients as often as is necessary to ensure high quality patient care and to comply with accepted professional standards;

(6) document patient consent in accordance with the Facility's requirements and policy;

(7) maintain adequate medical records in the format required by the Facility, ownership of which will vest in the Facility, sufficient to meet professional obligations for safe patient care and consistent with the accreditation or certification standards that apply to the Facility;

(8) comply with the *Privacy Act 1988* (Cth) and all applicable privacy legislation and privacy policies of PMA and the Facility in respect of the medical records and all personal information;

(9) comply with all reasonable requests made by the Facility with regard to personal conduct at the Facility and, subject to clinical considerations, to the use of medical supplies and equipment of the Facility and the provision of services at the Facility;

(10) adhere to the generally accepted ethics of professional practice both in relation to colleagues and to patients;

(11) observe the general conditions of clinical practice applicable to the Facility;

(12) comply with PMA's policies regarding the presence in clinical areas of persons who are employed or engaged by medical equipment or device companies to promote and/or demonstrate the use of equipment and devices;

(13) maintain with an insurer approved by PMA an adequate level of professional indemnity insurance covering the authorized Scope of Clinical Practice and in accordance with standards approved from time to time by PMA;

(14) furnish annually to the Facility documentary evidence of professional indemnity insurance including the level of cover and advise the Facility immediately of any material changes to the level of or conditions associated with professional indemnity insurance;

(15) be available or deputise an appropriately qualified Accredited Health Professional for emergency calls to the Accredited Health Professional's patients and participate in formal on call arrangements as required by the Facility;

(16) participate in the Facility's clinical quality improvement program;

(17) meet all reasonable requests to participate in the education and training of medical and other professional, nursing and technical staff of the Facility and of students attending the Facility including facilitating the availability of appropriate patients for clinical teaching, subject to:

(a) any contrary instructions by either the Treating Medical Practitioner or the Clinical Manager/Director of Nursing; and

(b) informed consent being given by the patient;

(18) attend regularly and when reasonably so required participate in such pertinent clinical meetings, seminars, lectures and other training programs as may be organized and held at the Facility;

(19) seek approval in accordance with these Facility Rules to undertake or use any New Clinical Services, Procedures or Equipment or undertake any Research;

(20) not aid or facilitate the provision of care by persons who are not Accredited Health Professionals, including without limitation utilizing surgical assistants who are not Accredited in accordance with these Facility Rules or who are not in appropriate training positions at the Facility;

(21) comply with any statutory regimes as required by any working with children legislation or legislation with similar objectives applicable to Health Professionals, including without limitation advising the Facility if they are charged with having committed or are convicted of a sex or violence offence;

(22) authorise the Facility to conduct a criminal history check with the appropriate authorities at any time;

(23) comply with all laws and Facility policies and procedures in relation to occupational health and safety, anti-discrimination, bullying and harassment;

(24) not represent in any way that they represent PMA or the Facility in any circumstances, including the use of Facility letterhead, unless with the express written permission of the CEO;

(25) subject to Rules 130 to 135, not disclose any confidential information of the Facility or PMA without prior written consent of the CEO of the Facility or a director or officer of PMAF Board as the case may be;

(26) except in an emergency, not initiate Treatment for any patient without the referral or consent of the admitting Accredited Practitioner recorded in the patient's medical records;

(27) comply with the administrative requirements of a Facility, including but not limited to completing authority scripts for dispensed medications and providing Commonwealth Medicare Benefits Schedule item numbers to the Facility in a timely manner;

(28) not use any prostheses within the Facility unless the prostheses are purchased by the Facility;

(29) comply with the *Health Practitioner Regulation National Law (NSW) 2009* (and the corresponding law as adopted in each State; and

(30) notify the CEO of a Facility immediately if he/she makes a notification to the Australian Health Practitioners regulatory agency regarding another Health Practitioner who is employed by or accredited at that Facility.

(31) The admission of an Accredited Practitioner's patients to the Facility is subject to bed availability and the availability and adequacy of nursing or allied health staff or facilities at the relevant Facility given the type of Treatment proposed to be conducted.

SCHEDULE 2
CONDITIONS ASSOCIATED WITH ACCREDITATION CLASSIFICATIONS

A. Specialist Practitioners, General Practitioners, Staff Specialists and Dentists:

(1) may admit and Treat patients within their authorized Scope of Clinical Practice, Accreditation Classification and/or conditions of Accreditation;

(2) must assume responsibility for the clinical care of patients admitted under their care;

(3) must not admit patients without and arrangement in place for another Accredited Practitioner of an appropriate Accreditation Classification and Scope of Clinical Practice to be available for emergency calls to the Accredited Health Professional's patients in the event that they are unavailable or unable to be contacted;

(4) must participate in continuing education activities of the Facility; and

(5) are eligible to be full members of the MAAC and Medical Council (if applicable).

(6) General Practitioner obstetricians may not admit or Treat patients without the ongoing support of a Specialist Obstetrician and both must be compliant with the Royal Australian and New Zealand College of Obstretricians and Gynaecologists' Guidelines and Accredited at the facility.

B. Surgical Assistants:

(1) may not admit patients, but may assist in theatre and visit patients in ward areas and examine clinical records of Patients in whose care they are involved excluding initiating or changing Treatment orders;

(2) may have their Scope of Clinical Practice limited to a particular specialty or surgeon;

(3) may participate in continuing education activities of the Facility; and

33.3 are not eligible to be members of the MAAC or Medical Council (if applicable).

C. Consultant Emeritus;

(1) may not admit patients unless they also are Accredited under a classification to. which admission rights attach;

(2) if they are able to admit patients under Schedule 2.C(1), must not admit patients without an arrangement in place for another Accredited Practitioner of an appropriate Accreditation

Classification and Scope of Clinical Practice to be available for emergency calls to the Accredited Health Professional's patients in the event that they are unavailable or unable to be contacted;

(3) may consult with other practitioners on the care of their patients within their Scope of Clinical Practice;

(4) may participate in continuing education activities of the Facility; and

(5) are eligible to be members of the MAAC and Medical Council (if applicable) but have not voting rights unless they also have an Accreditation Classification which voting rights attach.

D. Fellow Practitioners, Registrars and Career Medical Officers:

(1) may not admit patients;

(2) may only Treat patients under the supervision of an Accredited Practitioner, except in the event of a medical emergency;

(3) may participate in continuing medical education activities of the Facility; and

(4) are not eligible to be members of the MAAC or Medical Council (if applicable).