ESSENDON
PRIVATE CLINIC
Excellent Mental Health care in the Northwest

BY-LAWS

for
Visiting Practitioners (VP)

35 Rosehill Road
Essendon West 3040

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By-Laws for Visiting Practitioners

THE ESSENDON PRIVATE CLINIC

The Essendon Private Clinic is a fully accredited 32 bed Private Mental Health Hospital. Essendon Private Clinic (EPC) is part of IPHoA/Macquarie Health Corporation

HOSPITAL GOVERNANCE

EPC is governed by the Hospital Board which delegates day to day needs to the Senior Management Committee (SMM), the members of which are Board Representatives, Hospital Director (HD) or Manager, the Clinical Services Manager (CSM),the Program Manager (as designated) and the Administration Manager plus other invitees from time to time.

GOVERNANCE ISSUES:

The governing body should ensure:

a) Strong leadership in safety and quality;
b) Comprehensive governance systems;
c) Clearly defined delegated authority;
d) Independence of processes;
e) Systematic reports on performance;
f) Transparency and accountability; and
g) Involvement of consumers and communities.
h) Review and audit processes for all reporting purposes

ORGANISATIONAL ISSUES

The organisation should ensure:

a) Visiting Practitioners (VPs) agree to comply with the policy for credentialing and defining the scope of clinical practice.
b) VPs and management have a clear understanding of the clinical need and capability of the organisation.
c) Appropriate mentoring and professional support is provided for the practitioner's clinical practice.
d) Compliance at all times with the Standards/Legislation.
e) Maintenance of comprehensive patient records;
f) Appropriate indemnity insurance for credentialed practitioners and credentialing committee members.

BY-LAWS FOR VISITING PRACTITIONERS (VPs)

The following By-Laws have been drawn up to help the users and the management of the Hospital to establish guidelines for optimum patient care.

WHY?

a) Health care facilities are not allowed to permit VPs to work without appropriate credentialing and defining their scope of clinical practice.
b) All information must be verified.
c) Prior to re-appointment, every VP is subject to re-evaluation by members of Medical Advisory Committee (MAC).
d) Credentialing exists to serve patients by enabling hospitals to ensure/appoint qualified VPs.
e) Defining the scope of clinical practice exists to ensure the delivery by qualified VPs of safe and quality health care.

MEDICAL ADVISORY COMMITTEE

The MAC, which is elected by VPs, is the advisory group to the SMM that oversees all approvals of VPs, as well as all related activities pertaining to VPs involvement in the Hospital. The Medical Advisory Committee has a representative from each area of practice. For EPC that means for example:-

- Psychiatrists

- General Practitioners with Mental Health interest/qualification

The MAC is a peer group with the clear objective of ensuring that an acceptable professional working environment in all aspects, is maintained for the benefit of patients, VPs and the Hospital.

STRUCTURE OF THE MEDICAL ADVISORY COMMITTEE (MAC)

a) The MAC shall consist of appointed and/or elected VPs that represent the Hospital's clinical departments.
b) The MAC shall elect office bearers to the position of Chairman, Deputy Chairman and Secretary; these office bearers shall be known as the Medical Executive.
c) Office Bearers of the MAC shall be elected for a 3 year term of office.
d) The number of office bearers is to be no less than 3.
e) Three members of the Committee shall constitute a quorum and no business shall be transacted at a meeting of the Committee unless a quorum is present.
f) Ordinary meetings of the MAC shall be held every 3 months at a time and place to be determined by the MAC
g) As part of the standing agenda items, the MAC shall consider patient feedback data, issues of safety and quality, and carry out a review of incidents of patient escalation of care which may include transfers out of the facility per Standard 9 of the National Safety and Quality Health Service Standards (NSQHSS). Other items as per the Terms of Reference of the Committee will also be considered.

MINIMUM CREDENTIALS REQUIRED

a) Education, qualifications and formal training
b) Evidence of previous experience
c) Practitioner references and referee checks
d) Continuing education
e) Registration
f) Professional indemnity Insurance
g) Current Curriculum Vitae
h) Proof of identity
i) EPC application form

USE OF THE HOSPITAL – INITIAL CREDENTIALS

a) Any registered Medical Practitioner is eligible to apply to use the facilities of the Hospital. This entails completing the application form, providing evidence of registration with the Australian Health Practitioner Regulation Agency (AHPRA) (i.e. Register of Practitioners), Medical Indemnity Insurance and evidence of any appropriate professional fellowship or membership. Two written references are also to accompany the application form. Referees will be contacted by the HD or the delegate to verify their credentials. Proof of current Medical Board Registration and Medical Indemnity Insurance must be submitted annually and evidence of recognition as a Specialist Practitioner (if appropriate) must also be submitted annually.
b) All visiting privileges will be subject to review by the SMM and MAC each triennium.
c) The Committees should review the clinical services being requested by the medical practitioner, including objective performance data and references. Once the reviews are complete, the Committee should determine if the services will benefit the patient population and are within the organisation's service needs and capacity before making any recommendations.
d) The SMM, in conjunction with the MAC Chairman, may withdraw permission for the use of the Hospital, at its discretion.
e) These By-Laws are subject to revision biennially or as required by the SMM or MAC. Amendments may be discussed by the MAC with recommendations to the SMM for consideration and if felt appropriate, acceptance. Copies of the By-Laws and amendments are available from the Hospital Director. The use of the Hospital by a VP is subject to their observing the By-Laws of the Hospital and adhering to them.
f) All VPs will receive on commencement a copy of the By-Laws and will be notified of all formalised amendments within 28 days of such amendments.
g) Reapplication is required every 3 years.

TEMPORARY CREDENTIALITY

The MAC Chairperson in conjunction with the HD may give temporary permission for VP rights. Thereafter, following approval by the MAC and the SMM, the name of the VP will be added to the VP Register.

VP CLINICAL RESPONSIBILITIES

a) The VP admitting the patient will be regarded as responsible for the care of the patient until such time as the HD and/or CSM is notified of referral and transfer to the care of another Doctor, who is approved to use the Hospital. Such action is to be confirmed in writing as part of the clinical file.
b) All patients and/or legal guardians are required to sign an approved document for informed consent for all procedures or treatment. This is the responsibility of the attending VP.
c) Discharge of a patient may be authorised only by the attending VP or another VP acting on their behalf.
d) VPs admitting patients to the Hospital must see their patients within 24 hours of admission and also to be available for contact at all times. This can be in person via direct telecommunications or through another nominated VP approved by the Hospital.
e) VPs shall assist, where possible, in cases of emergency and on request, in terms of the above provisions.
f) All approved VPs may be required to assist and advise the Hospital on clinical matters which from time to time may arise.
g) All leave is to be notified. If an accredited VP wishes to take a period of leave of absence, they will give reasonable notice to the HD and/or CSM.
h) All VPs must participate in the clinical review of their patients, at a minimum, every three (3) days

PROTOCOLS FOR MANAGING PATIENTS - Medical

This section MUST be read in conjunction with EPC's governance and procedure manual ***Medical Staff Roles and Responsibilities Policy and Procedure and Scope of Clinical Practice*** which streamlines the processes of medical reviews and articulate the roles and responsibilities of medical staff working at the facility.

If VPs are not available in the case of any emergency, the Hospital is authorised to take such action as is deemed necessary in the interest of the patient. This may include a request for attention by an available VP or transfer to another hospital. In such cases the following provisions will apply:

- The Nurse in Charge will advise the CSM and/or HD of the action taken and the reason for this action.
- The patient's VP will be advised of the circumstances and the action at the earliest possible opportunity.
- The patient will be returned to the care of their VP or his/her deputy as soon as he/she becomes available and subsequent action will depend on the nature of the emergency and the normal process of consultation.

VP SCOPE OF PRACTICE

It is essential that all VPs who have independent responsibility for patient care at EPC are appropriately credentialed and have their scope of clinical practice defined in accordance with their level of skill and experience, and the capability and need of EPC. Defining the scope of practice follows on from credentialing and involves delineating the extent of an individual VP's clinical practice within EPC, based on the individual's credentials, competence, performance and professional suitability, and the needs and the capability of EPC to support the medical practitioner's scope of clinical practice. For a comprehensive guidance on scope of practice, these by-laws must be read in conjunction with the Department of Health and Human Services'

Credentialing and defining the scope of clinical practice for medical practitioners (2018) and ***Partnering for performance***
https://bettersafercare.vic.gov.au/reports-and-publications/credentialing-and-scope-of-clinical-practice-for-senior-medical-practitioners-policy

CRITICAL INCIDENTS & VPs

It is an obligation of VPs to cooperate fully in any Root Cause Analysis and college peer review such as CHASM etc if involved in such events

VP HOSPITAL ASSISTANCE

a) The Hospital can only stay in the business of supporting VPs provided all VPs recognise their direct impact on the costs and staffing of the Hospital. In so doing it is essential that VPs understand the method and amount of payment of rebates by Health Funds.
b) Risk Management is assured by improved prevention methods involving clinical, operational, communications and a recognised understanding of Hospital pressures in all areas.
c) Cost pressures can often be linked to VP performance and attitudes. Accordingly it is the responsibility of the VP to always minimise costs where they can. Suggestions to minimize costs are always appreciated and considered.

MEDICAL RECORDS/PATIENT HEALTH INFORMATION

a) The Hospital requires timely, accurate and informative documentation in order to provide appropriate patient care, and to meet the Department of Health's legal requirements. VPs are therefore expected to give high priority in this regard. The provision of full and correct details on and after admission in all aspects relevant to the care of patients, including their clinical history as well as clear and accurate instructions regarding medication and treatment is to be maintained at all times. Medical Orders must be **written legibly**, signed and dated, as required by the Hospital and by the Laws of the State.
b) All orders and instructions for treatment shall be given in writing. Telephone orders may be given by the VP to a Registered Nurse and repeated to a second Registered Nurse who will confirm by reading back the order given. The order must be written up and signed on the correct medical record form by the VP within 24 hours.
c) Medical Records which are the property of the Hospital are to remain confidential. In so doing, it is recognised that the VP attending the patient and Hospital employees will have constant access to these records.
d) All patients have a legal right on written and duly signed application to view their clinical file provided that such access in no way jeopardises their patient's care nor interferes with, alters or defaces their medical records. Patients may have access to their file if the VP is agreeable. The Doctor or Nurse in Charge must be in attendance to explain the records and then document that this has occurred in the patient's clinical file.

ETHICS

a) EPC is entitled to expect adequate and reasonable standards of personal competence and professional conduct from VPs.
b) It is expected that the VP should adhere to the accepted ethics of professional, clinical practice both in relation to his/her colleagues and to the patients under their care and observe the general conditions of clinical practice acceptable in the Hospital.

CLINICAL REVIEW

EPC is committed to quality care provision and thus has an ongoing program of clinical review, this is in the interests of maintaining institutional and professional standards and involves all VPs who are required to participate on a regular basis.

CONSENT

Patient information and Consent to Medical Treatment Policy Statement

1. All patients need to give written informed consent before undergoing a procedure or treatment – which protects from actions for assault and battery;
2. All patients need to be informed of the material risks associated with any procedure or treatment. This is standard practice, and practitioners who fail to provide this information before patients undergo any procedures risk an action for negligence;
3. Responsibility for the above is with the attending VP. Hospital employees cannot be delegated the task of informing a patient about the material risk of a procedure or treatment and obtaining consent;

4. No procedure or treatment may be undertaken ***without*** patient consent. Adequately informing patients and obtaining consent in regard to any procedure or treatment is both a specific legal requirement and an accepted part of good medical practice.

'VALID' CONSENT:

EPC's policy is that all patients consent to clinical care requiring hospitalisation on every admission via the Patient Code of Conduct.
For procedures or treatment where there are known risks or complications, a specific consent form is applied.
In such instances, the ***criteria for obtaining a valid consent must still be met*;** the procedure must still be explained to the patient which is supported by an entry in the medical record.

DISCLOSURE OF PECUNIARY INTERESTS

SPECIFIC DISCLOSURE

A member of a Hospital committee or a person authorised to attend any committee meeting who has a direct or indirect pecuniary interest:

- In a matter that has been considered or is about to be considered at a meeting, or
- In a thing being done or about to be done by the Hospital.

will as soon as possible after the relevant facts have come to the person's knowledge, disclose the nature of the interest at the meeting.

GENERAL DISCLOSURE

A disclosure by a person at a meeting of the committee that the person:
a) Is a member, or is in the employment of a specified company or other body,
b) Is a partner, or is in the employment of a specified person; or
c) Has some other specified interest relating to a specified company or other body or a specified person,

Is 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 disclosure.

OPEN DISCLOSURE POLICY

EPC's Open Disclosure policy forms part of the Hospital's overall risk management policy. The HD through the SMM and MAC, formulates and authorises open disclosure communication and correspondence where warranted. The elements of which may include:-
a) A factual explanation of what happened.
b) Consequences of the event,
c) Steps being taken to manage the event and prevent a recurrence.
d) MAC and SMM recommendations.

Every VP to EPC MUST be familiar with the latest guidelines on Open Disclosure. The latest document on this can be found here: http://www.safetyandquality.gov.au/wp-content/uploads/2013/03/Australian-Open-Disclosure-Framework-Feb-2014.pdf

PERSONAL COMMUNICATIONS DEVICES (PCD)

In order to maximise patient care and safety, the use of PCD's must be limited while attending patients unless directly related to patient care.

REQUESTING DRUGS, CONSUMABLES, EQUIPMENT AND OTHER SUPPLIES

There is a continuous change in availability of drugs, consumables, equipment and other supplies which are constantly requested by VPs. In order to control this, the VP must seek approval through the Hospital for the introduction of new items. This is to prevent unnecessary cost burdens on the Hospital without due consideration as to the merits of such a request.

AFTER HOURS AVAILABILITY

All VPs are expected to make themselves available for patient care matters after hours. If a VP is unavailable for a period of time, it is their responsibility to ensure an alternate VP is available.

APPEALS MECHANISM / SUSPENSION OF RIGHT TO PRACTICE

a) Any VP may appeal or request review of status, with regard to visiting rights and clinical privileges. Such a review will be conducted by the SMM assisted by the MAC. The SMM Committee may also refer to other bodies or parties. Any request for review should be directed to the MAC Chairman. Organisations may suspend a VP's right to practice for various reasons such as:-
   - Changes in the organisation's ability to provide support services;
   - Changes in the service needs of the organisation; or
   - Concerns about the VP's performance or competence.
   - A suspension may be temporary or permanent and may take effect in part or in whole.

b) A formal appeals mechanism exists for both the granting and the delineation of clinical privileges. The appeals mechanism may be invoked by the Practitioner who lodges the objection to the privileges they have been granted denied. The appellant has the right to make submissions to the Hospital, in writing within six months.

c) After registering an appeal through the HD, the SMM may nominate a committee to act as an Appeals Committee to hear the appeal. This committee shall consist of:-
   - Two representatives of the MAC.
   - Two representatives of the SMM.
   - A nominee requested of a recognised association e.g., Australian Medical Association or appropriate Learned College.

TERMINATION OF APPOINTMENT

Accreditation for Clinical Privileges to admit patients to the Hospital is an "at will "relationship between the Hospital and the VP. This relationship is not guaranteed and is able to be suspended or terminated upon written notification, without notice, and for any reason, by either party. Notwithstanding, the following situations will result in immediate suspension or termination of Clinical Privileges after notification by the HD to the MAC Chairman and/or a member of Corporate Management:

a) An appointment will be immediately terminated if an Accredited VP ceases to be currently registered with AHPRA.

b) Clinical Privileges may be suspended or terminated should a VP become incapable of performing their duties, or acting in an unprofessional way that is considered, by the Hospital, to be detrimental to patients or staff and the wellbeing of the Hospital.

c) The appointment of a VP may be at any time suspended or terminated by the HD and/or a member of Corporate Management where the VP fails to reasonably observe the terms and conditions of his or her appointment as a VP within the Terms of the By Laws herein, or is judged guilty of professional misconduct or unsatisfactory professional conduct.

d) Clinical Privileges may be suspended or terminated should a VP be party to a significant critical incident which results in the MAC determining their suspension or conclusion as the course of action.

e) In the event of the VP's Clinical Privileges being suspended or terminated, the HD will work with the VP concerned to ensure the safe transfer of patient care of any of their currently admitted patients in the Hospital to a suitably qualified VP. In the event that the VP is unavailable, unwilling or unable to confer with the HD to ensure the safe management of their patients through discharge or transfer of care to another VP or facility, the HD will notify the MAC Chairman for further instruction and will consult together with Corporate Management to achieve a safe outcome for the afore mentioned patients.

These By-Laws must be read in conjunction with Federal and State Laws, The Private Health Facilitates Regulation and any associated regulations.

Professional Ethics are to be read as per the Code of Ethics of the Australian Medical Association and the Learned Colleges.

Standard for Credentialing and Defining the Scope of Clinical Practice January 2018