



Group By-laws

April 2024

1. Definitions

- 1.1 **Accredited Medical Practitioner (AMP)** means a medical practitioner, dental practitioner or podiatric surgeon that has been granted Clinical Privileges at the Facility
- 1.2 **Board** means the board of directors of the Facility
- 1.3 **Clinical Privileges** means the right to treat patients at the Facility within a defined Scope of Clinical Practice. Granting of Clinical Privileges does not automatically extend the right for a Medical Practitioner to admit patients for treatment to the Facility.
- 1.4 **Company** refers to Nexus Hospitals
- 1.5 **Credentialing Committee** means the body responsible for evaluating applications for Clinical Privileges at the Facility
- 1.6 **Facility** means Manningham Private Hospital
- 1.7 **Nexus Clinical Governance Committee** means the body appointed by the Nexus Hospitals Board to provide advice to Nexus Hospital Management and the Nexus Hospitals Board in relation to clinical governance at Nexus Hospitals facilities.
- 1.8 **Nexus Hospitals Board** means the board of directors of Nexus Day Hospitals Holdings Pty Ltd
- 1.9 **Procedures** may refer to diagnostic or interventional procedures
- 1.10 **Scope of Clinical Practice** means the specialty, procedures or treatments for which a medical practitioner is granted Clinical Privileges
- 1.11 **Services** may refer to treatments, programs or procedures provided by or accommodated at the Facility
- 1.12 **Specialties** refers to the medical practitioner specialties recognised by the Australian Health Practitioner Regulation Agency (AHPRA)

2. By-Laws Purpose and function

- 2.1 These By-laws are the management policies approved by the Board which apply to all Accredited Medical Practitioners. The Board and Management of Nexus Hospitals recognises that the primary therapeutic relationship is between the admitting Accredited Medical Practitioner and the patient.
- 2.2 Amendment to By-Laws
In consultation with the Manningham Private Hospital Medical Advisory Committee (MAC), these By-laws may be amended by Nexus Hospitals from time to time.

3. Medical Advisory Committee (MAC)

- 3.1 Medical Advisory Committee Purpose
The Manningham Private Hospital Medical Advisory Committee (MAC), shall review and provide advice to the Manningham Private Hospital Board, Nexus Hospitals Board and Manningham Private Hospital Management in relation to the accreditation of Medical Practitioners, patient care and safety, and to provide a forum for open communication.
- 3.2 The appointment and responsibilities of the Medical Advisory Committee, and process of accreditation of Medical Practitioners is governed by the Nexus Facility MAC Terms of Reference as amended from time to time (see Appendix 1)

4. Confidential information

- 4.1 Subject to clause 4.3 of these By-laws, every Accredited Medical Practitioner must keep confidential the following information:
- a. Business information concerning the Company or the Facility;
 - b. Information concerning the insurance arrangements of the Company;
 - c. The proceedings relating to the accreditation and determination of Scope of Clinical Practice of the medical practitioner;
 - d. Discussions relating to performance of any Accredited Medical Practitioner;
 - e. Sentinel events and clinical incidents; and
 - f. Information concerning any patient or member of the staff of the Facility.
- 4.2 The confidentiality requirements of clause 4.1 of these By-Laws prohibit the recipient of the confidential information from using it, copying it, disclosing it to someone else, reproducing it or making it public.
- 4.3 When confidentiality can be breached
The confidentiality requirements of clause 4.1 of these By-Laws do not apply in the following circumstances:
- a. Where disclosure is required by law;
 - b. Where disclosure is required by a regulatory body in connection with the Accredited Medical Practitioner or the Facility;
 - c. Where the person benefiting from the confidentiality consents to the disclosure or waives the confidentiality; or
 - d. Where disclosure is required in order to perform any requirement of these By-laws.
- 4.4 Confidentiality obligations continue
The confidentiality requirements of clause 4.1 of these By-Laws continue with full force and effect after the Accredited Medical Practitioner ceases to be accredited.

5. Accreditation of Medical Practitioners

- 5.1 Purpose
The purpose of accreditation is to ensure that there is evidence of appropriate credentials and a defined Scope of Clinical Practice for medical practitioners applying for Clinical Privileges at the Facility. The accreditation process is in keeping with the requirements of the relevant state or territory department of health.
- 5.2 Accreditation process
The process of accrediting medical practitioners, and the granting, reviewing, suspension and termination of Clinical Privileges is the responsibility of the Manningham Private Hospital Board under the advice of the MAC (Appendix 1: Nexus Facility Medical Advisory Committee Terms of Reference cl. 6.1-6.13)

6. Introduction of new Clinical Services, Procedures and Other interventions

6.1 Definition of New Procedure

A New Procedure means a new interventional technology or procedure being introduced in the Facility for the first time, or an interventional technology or procedure not routinely performed by the Accredited Medical Practitioner seeking to perform such procedure in the Facility for the first time.

6.2 An interventional technology or procedure may be deemed to be a New Procedure (or substantially new) at the discretion of the Medical Director or Director of Nursing.

6.3 Once deemed a New Procedure, and prior to treating patients with the following:

- A new technology;
- A new instrument;
- A new procedure; or
- Altered technology or instruments used to treat patients,

The AMP is required to obtain the written approval of the MAC and Board (or Director of Nursing as delegate) prior to treating patients with the New Procedure.

6.4 In the event that the Accredited Medical Practitioner requires approval from the MAC and Board prior to the next ordinary meeting of the MAC, the Director of Nursing in conjunction with the Medical Director have the discretion to grant temporary approval.

6.5 Prior to admitting patients for treatment with the New Procedure, the MAC should consider if the AMP's medical indemnity insurance is appropriate for the New Procedure, what training is required and if appropriate training is available through the manufacturer or otherwise, before approving the treatment of patients with the New Procedure.

6.6 The introduction of clinical services and procedures within a New Specialty, defined as a medical specialty as recognised by AHPRA that is not already performed at the Facility, requires the approval of both the MAC and the Nexus Clinical Governance Committee. The requirement of approval by the MAC may be satisfied by the MAC recommending that clinical privileges be granted to a Medical Practitioner in a New Specialty.

7. Participation in Research Activities

7.1 Before any activities related to medical research may be undertaken at the Facility, approval must be given in writing by both the MAC and the Nexus Clinical Governance Committee.

7.2 The following documentation will be required by the MAC and Nexus Clinical Governance Committee prior to considering the application to conduct medical research:

1. A letter from the Accredited Medical Practitioner(s) involved describing their planned involvement in the research, details of the procedures involved, the potential impact on the Hospital, and any conflicts of interest to disclose (including financial support or payments to the AMP)
 2. Proof that the research has been approved by an appropriately constituted National Health and Medical Research Council (NHMRC) accredited human research ethics committee.
 3. Confirmation that necessary insurance cover is provided under current Nexus insurance policies.
- 7.3 The MAC should be satisfied that the protocol contained within the ethics committee application can be complied with and accurately represents the capacity of the Facility and its services.
- 7.4 The MAC should make its own assessment of the clinical risks involved, with external advice if necessary.
- 7.5 The DON should quantify the nursing, consumables and equipment requirements relating to the study. The DON should also provide confirmation to the Board that the Facility's insurance provides appropriate cover for any proposed medical research activities.
- 7.6 If the proposed research activities involve a new procedure to the hospital, then the introduction of New Procedure process should also be followed (see 6.1-6.5).

8. Responsibilities of Medical Practitioners

- 8.1 Professional conduct
Accredited Medical Practitioners are required to comply with the Facility Code of Conduct (Appendix 2) as well as any standards, Regulations, Acts, Laws and policies relating to their practice as an Accredited Medical Practitioner.
- 8.2 An Accredited Medical Practitioner is required to always treat patients in accordance with their Scope of Clinical Practice as defined by the terms of their accreditation, and within the limits of their professional registration.
- 8.3 Use of logos and trademarks
Unless a practitioner has prior written approval of the Director of Nursing, a practitioner may not use any Nexus Hospitals trademark, logo or letterhead in any way that would purport that the practitioner represents the Facility or Nexus Hospitals.
- 8.4 Behaviours in violation of By-Laws
AMPs must report to the Director of Nursing knowledge of any violation of these By-Laws, or any information of concern that may indicate that an Accredited Medical Practitioner is unfit for practice.

- 8.5 Disclosure obligations
AMPs must disclose any pecuniary interest that they (or any related party) may have a duty to disclose to the Facility, Nexus Hospitals or any associated entity in accordance with applicable Acts or Regulations, and where required by the AMP's membership or registration with a professional body.
- 8.6 Privacy and Confidentiality
Accredited Medical Practitioners must abide by patient confidentiality principles as well as the confidentiality provisions described in 4.1-4.4.
- 8.7 Open disclosure
Accredited Medical Practitioners agree to adhere to Open Disclosure principles as well as the Facility's Policies and Procedures on Open Disclosure.
- 8.8 Surgical complications and Post-Operative infections
All AMP's are obliged to contact the facility Director of Nursing as soon as possible in the event they become aware of a post-operative complication or infection requiring treatment, relating to a patient's admission to the Facility.
- 8.9 Provision of data necessary to billing
AMPs shall ensure that all data reasonably necessary to allow the facility to collect revenue is provided. This includes but is not limited to discharge summaries, medical certificates and other documents as required.
- 8.10 Participate in quality activities
The Facility will undertake reviews and audits in the interests of maintaining quality assurance and professional standards. All AMPs are required to participate where relevant, and to comply with relevant policies, procedures and guidelines of the hospital.
- 8.11 AMPs are required to participate in continuing professional education activities as appropriate and as required by their relevant professional body and will contribute to continuous improvement by recommending improvements that may improve the quality and safety of patient care. AMPs are to provide evidence of their compliance with the continuing professional development requirements of their relevant professional body to the hospital upon request.
- 8.12 AMPs will participate in the timely collection of data pertaining to the hospital's participation in Clinical Indicator collection or other quality activities.
- 8.13 AMPs will ensure that medical indemnity insurance appropriate to the AMP's Scope of Clinical Practice is maintained at all times.
- 8.14 AMPs will cooperate with any investigations undertaken by Facility management or the MAC relating to the AMP
- 8.15 Alterations to credentials
An Accredited Medical Practitioner is required to promptly advise the Medical Advisory Committee (or DON as delegate) if any of the following occur:
- A statutory professional registration board makes an adverse finding against the AMP;

- A statutory professional registration board revokes or suspends the AMP or places any condition, notation or limitation on the AMP's registration or right to practice;
- Membership of a medical defence organisation is not renewed or made conditional in any way, or full insurance cover is not in place for any reason;
- The AMP's appointment as an Accredited Medical Practitioner at another hospital is changed in any way; or
- The AMP is charged with or convicted of a serious criminal offence.

8.16 Suspension of accreditation

On the advice of the Medical Director, the Board may in consultation with the Director of Nursing suspend the accreditation of an AMP if the Medical Director believes that:

- Patient care or safety is being compromised by the AMP;
- The efficient operation of the facility is being unduly hindered by the AMP;
- The AMP is in breach of these By-laws; or
- The matter cannot be deferred until the next MAC Meeting.

8.17 The Medical Director may only suspend the accreditation of the AMP under 8.16 if the matter cannot be deferred until the next MAC meeting.

The Medical Director of the Facility will advise the AMP the reasons why accreditation is being suspended, and what action or actions required to be done within a specified period for the suspension to be lifted. An AMP's accreditation may only be suspended if the Medical Director of the Facility reasonably believes the matter can be rectified within a reasonable period of time by the practitioner.

8.18 Termination of accreditation

On the advice of the Medical Director, the Board may in consultation with the Director of Nursing terminate an AMP's accreditation immediately in the following circumstances:

- The AMP fails to rectify a matter notified in accordance with 8.17 within the time prescribed;
- A statutory professional registration board revokes or suspends the AMP or places any condition, notation or limitation on the AMP's registration or right to practice;
- The AMP has not exercised admission rights for a continuous period of 11 months;
- The clinical services able to be supported by the facility change for any reason;
- The AMP is found to have engaged in professional misconduct or unprofessional conduct by any statutory professional registration board, health ombudsman or healthcare complaints commission;
- Clinical skills and performance are consistently below an acceptable standard; or
- The AMP is convicted of any serious criminal offence

8.19 Fitness to practice

An assessment of an AMP's current fitness to practice evaluates the confidence able to be placed in the practitioner's ability to discharge the duty of care owed to patients. An assessment of fitness to practice may be undertaken by Internal Review or External Review.

8.20 Internal Review of fitness to practice

An Internal Review may be initiated by the Medical Director and undertaken by the Medical Director and the MAC. The Internal Review may be undertaken as part of an ordinary MAC meeting or by Extraordinary MAC meeting. The meeting must consist

of a Quorum and result in a vote by MAC members to recommend to the Board whether to continue, impose conditions upon, suspend or terminate an AMP's accreditation based on the MAC's assessment of the AMP's current fitness to practice. Following an assessment, the Medical Director will communicate in writing the MAC's recommendation to the Board.

8.21 Dispute Process

If the AMP concerned disputes the decision of the Board following an Internal Review of fitness to practice, the AMP may request an External Review under the following clause 8.22.

8.22 External Review of fitness to practice

An External Review may be initiated by the Medical Director and undertaken by a Medical Practitioner (Reviewer) who is not an Accredited Medical Practitioner of the Facility and independent of the AMP who is subject of the review. The Reviewer is required to provide a report to the Board. The report will be required to contain a summary of the Reviewer's assessment of the AMP's fitness to practice as well as a recommendation to continue, impose conditions upon, suspend or revoke the AMP's accreditation.

8.23 Board obligations following Internal or External Review

On receipt of the MAC's written recommendation following an Internal Review, or the External Reviewer's report following an External Review, the Board shall consider and respond in writing to MAC and the AMP concerned regarding the recommendation within 7 days.

8.24 A practitioner may request the Medical Director of the Facility to suspend accreditation for a stated period for good cause such as study leave so as to preserve the practitioner's right to automatically resume exercising privileges at the end of the period without having to re-apply for accreditation or without threat of termination for non-use of privileges.

8.25 Resignation

An AMP who wishes to resign their accreditation status shall forward a written resignation to the chairman of the Medical Advisory Committee, giving 14 days' notice.

8.26 Appeals relating to re-accreditation and Scope of Clinical Practice decisions

If an AMP disputes a decision not to reappoint the AMP, or to impose conditions or vary the AMP's Scope of Clinical Practice on reaccreditation, the AMP may seek a review of the decision up to 30 days after notice of the finding is deemed to have been received. A request for review is required to be in writing and addressed to the Medical Director of the Facility.

The requested review will be undertaken by the Medical Director and the MAC. This may be undertaken as part of an ordinary MAC meeting or by Extraordinary MAC meeting. Following the review, the Medical Director will communicate in writing the MAC's recommendation to the AMP and to the Board.

9. Clinical Guidelines

- 9.1 Patient rights and responsibilities
AMPs will adhere to the principles of the Australian Charter of Healthcare Rights (Appendix 3).
- 9.2 Management of care
An AMP is required to provide professional services with due skill, care and diligence in undertaking the responsibilities of preoperative diagnosis and care, the selection and performance of the appropriate operation or procedure, and postoperative surgical care.
- 9.3 Attend/Review patients
AMPs are required to ensure that all reasonable requests by Facility staff are responded to in a timely manner and in particular, patients are promptly attended to when reasonably requested by Facility staff for valid clinical reason.

10. Other AMP requirements

- 10.1 Admission Criteria
AMPs must adhere to the Facility's admission criteria at all times.
- 10.2 Consent
Explanation of the nature and risks of an operation is essential and is to be undertaken personally by the AMP. The practitioner admitting the patient must ensure that consent for any procedure or anaesthetic is documented (and signed by both the patient and AMP) on the Facility's consent form prior to commencement of the procedure or anaesthetic.
- 10.3 Financial Consent and Fee Conduct
AMPs must confirm with accepted standards of Informed Financial Consent. AMPs also agree, in line with the Royal Australasian College of Surgeons Code of Conduct, to ensure that the professional fees charged to patients are justifiable and reasonable and do not exploit a patient's need or take financial advantage of the patient.
- 10.4 Medication Management
AMPs must write all medication orders in the patient's medical record as well as completing any necessary prescription forms.
- Where medication is ordered by telephone, the order is to be provided to the Registered Nurse and her/his witness, and the order to be subsequently confirmed on the occasion of the AMP's next visit to the Facility, or otherwise as required by law.
- 10.5 Medical record documentation
An AMP must ensure that patient medical records are adequately and accurately maintained, including that they:
- Satisfy the standards required by NSQHSS accreditation practices and government legislation;

- Include all information and discharge instructions reasonably necessary to allow the Facility to care for patients.

10.6 Allocation and use of operating room sessions

Sessions shall be allocated to AMPs by management as it sees fit, taking into consideration the available times and the business needs of the Facility. AMPs are expected to have arrived in the facility and be ready to commence their operating session at the agreed time. In the event of unavoidable delay, the facility should be notified as soon as possible.

10.7 Admitting details

The patient's name, provisional diagnosis, the nature of the operation to be performed, the patient's age, telephone number, health insurance details etc. shall be notified to the Facility by the AMP or AMP delegate before a booking for admission can be confirmed. The nature of the planned anaesthetic and the name of the anaesthetist should also be advised.

10.8 If an operating session is required to be cancelled, it is required that a period of at least 14 days' notice shall be given to the Facility management.

10.9 Anaesthetics

For surgery involving the use of regional, general anaesthesia and/or sedation to commence, it is a requirement that at least one accredited anaesthetist is present in the hospital and prepared to be responsible for the patient. The AMP performing the surgery must be present in the facility before the anaesthetic or sedation is commenced.

10.10 Surgical assistants

The provision of a surgical assistant is the responsibility of the treating AMP. All surgical assistants must also be credentialed as an AMP by the Facility. Each AMP is responsible for the conduct of each assistant engaged by him or her.

10.11 Adherence to Facility Policies and Procedures

All AMPs will adhere to the Facility's policies and procedures as amended from time to time.

10.12 Pathology

AMPs must ensure that copies of all pathology reports relating to a patient's admission are supplied to the Facility for its records as soon as practicable.

10.13 Emergency situations

AMPs must advise the Director of Nursing in writing of any changes to their contact details (including mobile telephone numbers, email and postal addresses) along with the contact details for any locum practitioners responsible in the event of the AMP being unavailable in an emergency. In the event of an emergency involving a patient where the AMP cannot be contacted immediately, the DON or their delegate shall take whatever action is necessary in the best interest of the patient. The AMP will be notified as soon as possible and ongoing care of the patient will remain the AMP's responsibility.

10.14 Discharge of Patients

Discharge instructions and operation records are required to be completed by Accredited Medical Practitioners in a timely manner and all information reasonably necessary to safely discharge a patient. If overnight care is required, the discharge plan must be communicated to the facility prior to admission and any changes notified as soon as possible.

Appendix 1 – Nexus Facility Medical Advisory Committee Terms of Reference

1. Definitions

Definitions used in this Terms of Reference are those used in the Nexus Facility By-Laws

2. Terms of Reference Purpose and function

2.1 These Terms of Reference are the management policies approved by the Board which apply to the appointment and conduct of the Facility Medical Advisory Committee.

2.2 Amendment to Terms of Reference

In consultation with the MAC, these Terms of Reference may be amended by the Board from time to time.

2.3 Facility By-laws

These Terms of Reference are to be read in conjunction with the Facility By-laws as amended from time to time.

3. Medical Advisory Committee (MAC)

3.1 Medical Advisory Committee Purpose

The Manningham Private Hospital Medical Advisory Committee (MAC), shall review and provide advice to the Board, Nexus Hospitals Board and Manningham Private Hospital Management in relation to the accreditation of Medical Practitioners, patient care and safety, and to provide a forum for open communication.

3.2 The MAC will provide the Board and Management of the Facility consultation and advice on:

- The range of clinical services, procedures or other interventions that can be provided safely in the specific organisational setting,
- The facilities and clinical and non-clinical support services reasonably necessary to sustain the safe, high-quality provision of specific clinical services, procedures or other interventions,
- The accreditation of Medical Practitioners including defining the Scope of Clinical Practice to which a Medical Practitioner may be granted Clinical Privileges.
- Information that should be requested of, and provided by, applicants for appointment to specific positions or for a specific Scope of Clinical Practice,
- Other matters relating to patient safety.

3.3 The MAC will act as the Credentialing Committee, or if a separate sub-committee is nominated, provide oversight for the Credentialing Committee to undertake the processes of credentialing and defining the scope of clinical practice for Accredited Medical Practitioners. Where the Credentialing Committee is separately established, a reference in these Terms of Reference to the MAC (when performing a credentialing function) will be read as a reference to the Credentialing Committee.

- 3.4 The MAC will review and provide advice to the Board regarding:
- Investigations involving the [insert State/Territory regulator],
 - Internal and external audit findings,
 - Registration and scope of practice issues relating to Accredited Medical Practitioners,
 - Conflicts of interest involving medical practitioners.
- 3.5 Where nominated by the Board as separate bodies to the MAC, the MAC will oversee the following sub-committees:
- Antimicrobial Stewardship Committee
 - Credentialing Committee
 - Drugs and Therapeutics Committee
 - Other committees as nominated by Board
- 3.6 Communication
- The MAC will provide a forum for facilitating communication between the Facility, Accredited Medical Practitioners and the Nexus Clinical Governance Committee.
- 3.7 The MAC will advise the Board regarding the implementation of actions to manage risk and facilitate continuous improvement at the Facility. These may include:
- Eliminating adverse practices and behaviours that may be considered a risk to patient safety,
 - Introduction of new specialties, services or procedures
 - Modifying existing approved specialties, services or procedures
 - Monitoring of performance of AMPs including suspension or cancellation of Clinical Privileges
 - Changes to the infrastructure and staffing of the Facility
- 3.8 To report to the Director General (or other as required) of the Victorian Department of Health and Human Services any repeated failure by the Board to act on advice from the MAC on matters where the failure is likely to adversely impact on the health and safety of patients.
- 3.9 Review of MAC Terms of Reference
- These Terms of Reference may be amended by the Nexus Board from time to time, with any changes to be tabled for MAC comment at the next scheduled MAC meeting.
- 3.10 MAC composition (Ordinary Members)
- A minimum of 5 and not more than 10 representatives including:
 - a. Surgeon representatives (minimum 3) from at least two of the Facility's major surgical specialties;
 - b. Anaesthetist representatives (minimum 1);
 - c. Director of Nursing or delegate; and
 - d. The Medical Director, also acting as MAC Chair as the case may be.
- All of the above shall have voting rights.
- The following may attend MAC meetings in an ex-officio capacity and do not have voting rights:
 - a. The Facility CEO/General Manager;

- b. A representative of the Board;
 - c. Nexus Operations Directors;
 - d. Nexus Chief Operating Officer;
 - e. Nexus Chief Medical Officer; and
 - f. Others as agreed to by the MAC.
- 3.11 Medical Director
- 3.11.1 The Medical Director shall be appointed by the Board for a term of three years and shall be eligible for re-appointment. The Medical Director may also act as MAC Chair as determined by the Board, with equal voting rights to Ordinary Members.
- 3.11.2 To avoid financial conflicts of interest, wherever possible the Medical Director (or MAC Chair as appropriate) should not have an economic interest in the Facility.
- 3.12 MAC appointment process
- 3.12.1 Members of the Medical Advisory Committee will be appointed by the Board.
- 3.12.2 The Board must notify each member of the Medical Advisory Committee of the terms of their appointment, with a copy of these By-laws to accompany the notification if not previously provided.
- 3.12.3 Members of the Medical Advisory Committee shall be appointed for a period of three years unless otherwise notified in writing at the time of their appointment and shall be eligible for re-appointment.
- 3.12.4 Members of the Medical Advisory Committee are not entitled to and waive any and all claims for consideration for or in connection with their appointment to the Medical Advisory Committee (including salary, wages, directors' fees or any other fees and charges).
- 3.12.5 MAC Members who are not Accredited Medical Practitioners are to provide confirmation of registration with the Australian Health Practitioner Regulation Agency (AHPRA) and provide evidence of current Medical Indemnity Insurance.
- 3.13 MAC Power of Co-opt
- The MAC may co-opt the services of any other person it considers necessary to provide expert advice on any matter. The co-opted member shall not have voting rights.
- 3.14 MAC Resignation processes
- 3.14.1 A resigning member will provide notice in writing to the MAC Chair (with copy to the DON) providing at least one month's notice.
- 3.14.2 In the event of a resignation of an MAC medical member, the MAC may nominate another Medical Practitioner to be appointed by the Board.

3.14.3 The nominated Medical Practitioner must be appointed in accordance with 3.12.

3.15 Declaration of conflict of interest

Any real or potential conflicts of interests shall be advised to the Committee at the commencement of any meeting of the Medical Advisory Committee. In those area of conflict (real, potential or perceived), the Member shall abstain from voting.

3.16 Other MAC Member obligations

No MAC Member may purport to represent the Facility or Nexus Hospitals without the express written permission of the Board or the Managing Director, Nexus Hospitals

The marks, logos and symbols of the Company and the Facility may not be used without the written authorisation of the Board or its authorised delegate.

4. Confidential information

4.1 Subject to clause 4.3 of these Terms of Reference, MAC members must keep confidential the following information:

- Business information concerning the Company or the Facility;
- The particulars of these By-Laws;
- Information concerning the insurance arrangements of the Company;
- The proceedings for the Accreditation and designation of Scope of Clinical Practice of the Health Practitioner;
- Discussions relating to performance of any Accredited Medical Practitioner;
- Sentinel events and clinical incidents; and
- Information concerning any patient or staff member of the Facility.

4.2 The confidentiality requirements of clause 4.1 of these Terms of Reference prohibit the recipient of the confidential information from using it, copying it, disclosing it to someone else, reproducing it or making it public.

4.3 When confidentiality can be breached

The confidentiality requirements of clause 4.1 of these Terms of Reference do not apply in the following circumstances:

- Where disclosure is required by law;
- Where disclosure is required by a regulatory body in connection with a Accredited Medical Practitioner or the Facility;
- Where the person benefiting from the confidentiality consents to the disclosure or waives the confidentiality; or
- Where disclosure is required in order to perform some requirement of these Terms of Reference.

4.4 Confidentiality obligations continue

The confidentiality requirements of these Terms of Reference continue with full force and effect after a Medical Advisory Committee member ceases to be a member.

5. Conduct of MAC Meetings

- 5.1 Frequency of Meetings
Ordinary meetings shall be held as required but not less than 2 times per year.
- 5.2 Notice of Meetings
Fourteen days' notice in writing shall be provided for each ordinary MAC meeting.
- 5.3 Quorum
A quorum will include the Medical Director, the DON or delegate, and any Medical Practitioner MAC Members from at least two disciplines.
- 5.4 Postponement of meeting
Should it be apparent that there is not, or will not be, enough members to form a quorum, the DON may postpone the meeting and re-schedule at the next possible opportunity.
- 5.5 Extraordinary meetings
In the event there is a need for the MAC to address urgent business the Medical Director or DON may call an extraordinary meeting. The quorum for an extraordinary meeting will comprise the Medical Director, DON and one other MAC Member. The minutes of such meetings are to be tabled and ratified at the next scheduled MAC meeting.
- 5.6 Decisions
Decisions shall be made by a majority vote, with each MAC Member having a single vote, the MAC Chair holding a casting vote in the event there is no clear majority. In matters directly relating to accreditation of Medical Practitioners, the person to whom the discussion relates shall absent themselves from such discussion and endorsement of clinical privileges.
- 5.7 Emergency situations requiring a change in clinical/medical practice
Should there be an emergency situation at any time in which it is necessary to obtain the advice of the Medical Advisory Committee, the Medical Director (or if he or she is unavailable, another Accredited Medical Practitioner member of the MAC) and the DON (or delegate if the DON is unavailable), in consultation together, shall be empowered to undertake such necessary action (such action to be reviewed by the Medical Advisory Committee at the earliest possible opportunity). Where appropriate, the Medical Director (or alternate) and DON (or delegate) must consult with the surgeon or anaesthetist involved in the emergency.
- 5.8 MAC Meeting Minutes
Minutes will be recorded at each meeting and accepted as a correct representation of the meeting by the MAC Chair.
- 5.9 Distribution of Minutes
Draft minutes will be distributed within 30 days to MAC Members for review. Finalised MAC meeting minutes are to be signed by the MAC Chair as a true representation of MAC meeting proceedings and distributed by the Director of Nursing to the Nexus Chief Medical Officer and Chief Operating Officer for review by the Nexus Clinical Governance Committee.

5.10 Reports to be tabled at MAC meetings

Reports to be tabled at a meeting of the MAC shall include, and are not limited to, the following:

- Director of Nursing/General Manager report
- Quality reports including clinical indicators and incidents registers
- Consumer participation
- Non-conformance/accreditation action requirements
- Internal and external audit findings
- Infection Control audit reports
- Patient complaints

6. Accreditation of Medical Practitioners

6.1 Purpose

The purpose of accreditation is to ensure that there is evidence of appropriate credentials and a defined Scope of Clinical Practice for Medical Practitioners applying for Clinical Privileges at the Facility. The accreditation process is in keeping with the requirements of the relevant state or territory department of health.

6.2 Final approval of applications for Clinical Privileges

The Medical Advisory Committee, and its Credentialing Committee if nominated, is the body responsible to review applications for clinical privileges and to make recommendations to the Board regarding whether in its opinion applications should be approved. The Board shall have final authority to approve applications which have been recommended for approval by the MAC.

6.3 Clinical Privileges

Only Medical Practitioners who are Accredited Medical Practitioners may care for and treat patients at the Facility.

6.3.1 The following categories of health practitioners require approval from the Nexus Clinical Governance Committee in addition to the MAC or Credentialing Committee in order to be credentialed to practice at the hospital:

- Non-specialist Anaesthetists
- Podiatric surgeons
- Specialists performing procedures outside of the accepted scope of clinical practice for their designated specialty
- Nurse practitioners and Nurse Surgical Assistants

6.3.2 Not all categories of Accredited Medical Practitioner carry admission rights. Admitting rights are not provided for:

- Surgical assistants
- Career Medical Officers or Resident Medical Officers
- 3rd Party medical service providers such as radiologists or pathologists.

6.4 Accreditation of Non-specialist practitioners

Clinical privileges may only be approved for medical practitioners who do not hold specialist registration with the Australian Health Practitioner Regulation Agency or

relevant state or territory medical board on the written authorisation of the Nexus Clinical Governance Committee.

6.5 Emergency Accreditation

Emergency accreditation may be provided as required in the instance of a clinical emergency by the DON after consultation with the Medical Director. The period of Emergency accreditation is for twenty-four hours.

6.6 Temporary Accreditation

Temporary Accreditation may be granted by the Board for a period of up to 6 months prior to the MAC considering the application and recommending the appointment to the Board. Applications for Temporary Accreditation are made by completing an Application for Privileges form and submitting to the Medical Director or Director of Nursing. Temporary Accreditation will only be granted by the Board after consultation with the Director of Nursing and Medical Director. The criteria for the awarding of Temporary Accreditation are the same as those for Full Accreditation as defined in clause 6.9.

6.7 Applying for Clinical Privileges

A practitioner may apply for Clinical Privileges by submitting a completed Application for Privileges form to the Medical Director or Director of Nursing of the Facility. The Director of Nursing is required to submit the application to the MAC or Credentialing Committee as appropriate. Applicants may be accredited for a period of up to 3 years.

6.8 Provisional Accreditation

In certain circumstances, the MAC may decide to award a limited term of 12-months accreditation. This is to be reviewed at the conclusion of the Provisional Accreditation term after a longer term of accreditation of up to 3 years may be awarded.

6.9 Criteria for credentialing

- Evidence of minimal credentials
 - a. Curriculum vitae and evidence of undergraduate and specialist qualifications
 - b. Evidence of compliance with relevant continuing professional development requirements
- Professional referees
 - a. Two current referees who are preferably senior practitioners within the relevant area of specialist practice being applied for and have been in a position to judge the applicant's experience and performance during the last 3 years. Referees must have no conflict of interest in the awarding of Clinical Privileges to the applicant.
- Registration as a Medical Practitioner or Dental Practitioner with the Australian Health Practitioner Regulation Agency (AHPRA)
- Podiatric surgeons must be registered as a Podiatrist with AHPRA, and also provide evidence of postgraduate training in podiatric surgery
- Professional Indemnity Insurance
- Hand hygiene certification
- Pre-employment checks
 - a. Proof of identity
 - b. Police checks

c. Working with Children checks

6.10 Delineation of Scope of Clinical Practice

Any Medical Practitioner applying for clinical privileges should nominate their intended Scope of Clinical Practice within their indicated discipline. The MAC should take into consideration the applications qualifications and experience in considering the intended Scope of Clinical Practice. The MAC must also determine that the facility has adequate infrastructure, staffing and licensing necessary to accommodate the intended Scope of Clinical Practice. An Accredited Medical Practitioner is required to always treat patients within their Scope of Clinical Practice.

6.11 Register of Accredited Medical Practitioners

The Facility will keep a register of all AMPs in accordance with applicable regulations and NSQHS Standards.

6.12 Annual verification

An annual process of verification of Medical Registration and Medical Indemnity Insurance will be undertaken by Facility Management and recorded on the register of Accredited Medical Practitioners. Prior to expiry, AMPs must provide evidence of renewal of AHPRA Registration and Medical Indemnity Insurance with a term of not less than 12 months.

6.13 Confidentiality of credentialing matters

The process of credentialing Medical Practitioners, and the process for change to accreditation, including revocation or termination of accreditation are confidential and should not be disclosed to any person not involved in the process except in accordance with these By-laws.

Appendix 2 – Admission Criteria

During the pre-admission process, nursing staff will alert the DON (or delegate) of any patient who may not meet admission criteria.

For example, the DON (or delegate) will be notified immediately, should a patient at preadmission prior to admission, be:

- A weight greater than 120kg or a Body Mass Index greater than 40
- Under the age of 18 years
- Unable to weight bear / wheelchair dependent
- Currently undergoing chemotherapy treatment
- A current inpatient from an acute surgical facility
- Acute mental health treatment in a mental healthcare facility
- Known to have a current acute infectious status
- Of any concern to pre-admission nursing staff
- Surgically consented for bilateral intraocular surgery. NB – Bilateral Cataract Surgery requests must be requested by a surgeon to the DON (or in the DON absence, the delegate), in consultation with the Medical Director for consideration on a case by case basis.
- Deemed (by the Anaesthetist on admission) to have an ASA score of 4 or greater.
- End of Life care is not provided

During the pre-admission process should any of the above be identified, the DON (and or Medical Director), Surgeon and Anaesthetist discuss the appropriateness and risk management issues pertaining the patient's admission to MPH.

Should a patient have a BMI greater than 40, the Surgeon, Anaesthetist and a Medical Advisory Committee Anaesthetic representative will discuss the appropriateness and risk management issues pertaining the patient's admission to MPH.

The MPH Board of Directors supports the right of the DON / Medical Director to refuse the admission of any patient deemed to be beyond the level of acceptable risk as outlined above but not limited to.

Appendix 3 – Facility Code of Conduct



CODE OF CONDUCT

The MPH Code of Conduct provides guidelines regarding the appropriate way to interact with patients, visitors and other staff. Adhering to the guidelines will assist in the delivery of high-quality patient focused care and create a working environment where both the rights and responsibilities of patients, visitors and staff are acknowledged.

Professional Behaviour

Use our knowledge and skills to perform our duties to the best of our ability

- Be willing to demonstrate openness in our interaction with others
- Treat people fairly without prejudice and acknowledge their achievements
- Treat people with courtesy and sensitivity respecting their right to confidentiality
- Use every opportunity to enhance our knowledge and skills and be generous in sharing our knowledge and skills with others
- Acknowledge our limitations and be willing to seek advice from others
- Be open to receive constructive feedback from others

Collaborative Working Environment

Foster collaboration by working together

- Promote an atmosphere of trust, respect and open communication
- Recognise, acknowledge and respect individual difference including gender, personal attributes, spiritual values, sexual preferences, political beliefs, age, disability and culture
- Work towards a safe, healthy and creative environment
- Aspire to gain enjoyment and satisfaction from working together

Communication

Communicate with respect and tolerance

- Foster sincere and open discussion of ideas and opinions
- Discuss differences in a clear and calm manner without using language or behaviours that are abusive, intimidating, sarcastic or patronising
- Provide feedback via satisfaction surveys

Resolving conflict

Work constructively to resolve conflict calmly in a timely manner

- Listen to the views of the person in conflict and endeavour to work with them to resolve differences
- Seek appropriate mediation if the conflict is not being resolved in accordance with the MPH grievance procedure.

Appendix 4- Quality Policy



The senior management team and staff at Manningham Private Hospital are committed to ensuring that a robust Quality System is in place as directed by the Quality System Manual to:

Planned outcomes

- To provide a timely, safe, healthcare service, which encompasses measurable ongoing continual improvement to our customers, as a basis of all practices
- To provide healthcare of a high standard using a risk focused, process approach, based on Best Practice and regulatory requirements
- Provide a competitive, affordable and safe health care service to our customers
- Engage regularly with our customers, both internal and external, to ensure we are meeting their needs effectively
- Regularly review and assess the effectiveness of our Quality Management System and implement improvements, which is based on AS/NZ 9001:2016
- Ensure Manningham Private Hospital's Quality Policy is available to all interested parties

We have processes in place for the ongoing transparent planning, review and improvement to our Quality Management System. The outcome of the planning process is a set of objectives which will be reviewed and updated at least annually.

It is important that Manningham Private Hospital stakeholders:

- Are aware of the requirements of our Quality Management Systems,
- Identify, Record, Report all problems, incidents, complaints, compliments or areas for improvement
- Comply with the intent and the content of our Quality Management system

Please contact Manningham Private Hospital's GM or Director of Nursing if you require further information on our Quality Policy

AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

1 Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.

2 The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.

3 Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.



For further information please visit www.safetyandquality.gov.au

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

What can I expect from the Australian health system?

MY RIGHTS	WHAT THIS MEANS
Access I have a right to health care.	I can access services to address my healthcare needs.
Safety I have a right to receive safe and high quality care.	I receive safe and high quality health services, provided with professional care, skill and competence.
Respect I have a right to be shown respect, dignity and consideration.	The care provided shows respect to me and my culture, beliefs, values and personal characteristics.
Communication I have a right to be informed about services, treatment, options and costs in a clear and open way.	I receive open, timely and appropriate communication about my health care in a way I can understand.
Participation I have a right to be included in decisions and choices about my care.	I may join in making decisions and choices about my care and about health service planning.
Privacy I have a right to privacy and confidentiality of my personal information.	My personal privacy is maintained and proper handling of my personal health and other information is assured.
Comment I have a right to comment on my care and to have my concerns addressed.	I can comment on or complain about my care and have my concerns dealt with properly and promptly.