



# By-Laws

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## 1. Preface

- 1.1 Cura Day Hospitals Group Pty Ltd (hereinafter referred to as Cura) owns and operates private day hospitals in Australia.
- 1.2 Cura aims to be the acknowledged leader in the provision of quality private day hospitals (Hospitals), which are recognised by leading industry accreditation bodies.
- 1.3 Cura provides and maintains modern and well-equipped Hospitals to the highest safety standards, enabling its Specialist Medical Practitioners to focus exclusively on Cura patients.
- 1.4 Cura believes that a safe working environment is essential to quality health care and patient well-being.

## 2. Values of Cura

- 2.1 Cura's values are:

**Leadership:** Inspiring our employees and Specialist Medical Practitioners to continually contribute their best through support, encouragement and being an innovative organisation.

**Integrity:** Each employee and Specialist Medical Practitioners are accountable for their actions, their honesty and behaving in an ethical manner by doing what is right.

**Excellence and Quality:** Delivering consistently high service to all people; being responsive to the needs of others and continually striving to achieve the best in patient satisfaction.

**Teamwork:** Our people work together cohesively towards a common goal, creating a positive working atmosphere and supporting each other to combine individual strengths to enhance team performance.

**Respect:** Treating everyone in our communities, our patients, their families, and colleagues with dignity at all times.

The above values are used as a guide in the application of these By-Laws.

## PART A – Definitions and Introduction

### 3. Definitions and Interpretation

#### 3.1 Definitions

In these By-Laws, unless indicated to the contrary:

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

**Accredited** means the status conferred on a Medical Practitioner, Dentist, Allied Health Professional or Advanced Practice Nurse to provide services within Cura after having satisfied the Credentialing and Scope of Practice requirements provided in these By-Laws.

**Accredited Perioperative Nurse Surgical Assistant** means a Perioperative Nurse Surgical Assistant who has been Accredited to provide services within Cura and is an Accredited Practitioner for the purposes of these By-Laws.

**Accredited Practitioner** means a Medical Practitioner, Dentist, Allied Health Professional or Advanced Practice Nurse who has been Accredited to provide services within Cura.

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

**Advanced Practice Nurse or APN** means a Registered Nurse who practises at an advanced clinical level under the Health Practitioner Regulation National Law Act 2009 (Cth) and includes a Nurse Practitioner and a Perioperative Nurse Surgical Assistant. For the avoidance of doubt, Advanced Practice Nurses (including Nurse Practitioners and Perioperative Nurse Surgical Assistants) are not Allied Health Professionals for the purposes of these By-Laws and are governed by clause 15A.

**AHPRA** means the Australian Health Practitioner Regulation Agency established under the National Law.

**AI Core Values** means the AI Core Values set out in section 3 of the AI Governance Framework.

**AI Governance Framework** means Cura's Artificial Intelligence (AI) Governance Framework as updated from time to time, together with any policies, procedures, or registers made under it, including the AI Use Policy and Approved AI System Register.

**AI system** means a machine-based system that, for explicit or implicit objectives, infers, from the input it receives, how to generate outputs.

**AI Use Policy** means Cura's AI Use Policy as amended from time to time.

**APN Credentialing Committee** means the credentialing committee established in accordance with clause 15A.2.

**Approved AI System Register** means the internal list of AI use cases and AI systems approved for use within Cura, maintained by the Head of IT, as amended from time to time.

**Allied Health Privileges** means the entitlement to provide treatment and care to patients as an Allied Health Professional within the areas approved by the Hospital CEO/Director of Nursing of the Relevant Hospital in accordance with the provisions of these By-Laws. This includes an Allied Health Professional who is a Podiatric Surgeon.

**Allied Health Professional** means a person registered by AHPRA as an Allied Health Professional pursuant to the National Law or other categories of appropriately qualified health professionals as approved by the Chief Executive Officer. This includes a person who is a Podiatric Surgeon.

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

**Behavioural Standards** means the standard of conduct and behaviour expected of an Accredited Practitioner arising from personal interactions, communication and other forms of interaction with other Accredited Practitioners, employees of the relevant hospital, Board members, executives of the relevant hospital and Cura, third party service providers, Patients, family members of Patients and others. The minimum standard required of Accredited Practitioners in order to achieve the Behavioural Standards is compliance with the Cura Code of Conduct for Workers, the expectations set out in the applicable National Board Code of Conduct, and the values set out in the By-laws.

**Board** means the Board of Directors of Cura.

**By-Laws** means these by-laws.

**Chief Executive Officer (CEO)** means the Chief Executive Officer of Cura or any person acting, or delegated to act, in that position.

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

**Code of Conduct** means Cura's Code of Conduct for Workers.

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

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

**Credentialing** means, in respect of a person who applies for Accreditation or Re-Accreditation, the formal process used to match the skills, experience and qualifications to the role and responsibilities of the position. This will include actions to verify and assess the identity (including the required level of identity check), education, formal qualifications, equivalency of overseas qualifications, post-graduate degrees / awards / fellowships / certificates, professional training, continuing professional development, professional experience, recency of practice, maintenance of clinical competence, current registration and status, indemnity insurance, and other skills/attributes (for example training and experience in leadership, research, education, communication and teamwork) for the purpose of forming a view about their Credentials, Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care services within specific environments. Credentialing involves obtaining evidence contained in verified documents to delineate the theoretical range of services which an Accredited Practitioner is competent to perform.

**Credentialing and Scope of Practice of Health Professionals Policy** means the Cura Credentialing and Scope of Practice of Health Professionals Policy, as updated from time to time.

**Cura** means Cura Day Hospitals Group Pty Ltd and its subsidiaries.

**Current Fitness** is the current fitness required of an applicant for Accreditation or Re-Accreditation to carry out the Scope of Practice sought or currently held, including with the confidence of peers and Cura / Relevant Hospital, having regard to any Relevant physical or mental impairment, disability, condition or disorder (including due to alcohol, drugs or other substances) which detrimentally affects or there is a reasonably held concern that it may detrimentally affect the

person's capacity to provide health services at the expected level of safety and quality having regard to the Scope of Practice sought or currently held.

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

**Director of Nursing** means the person appointed to the position of director of nursing, or equivalent position by whatever name, of the Relevant Hospital or any person acting, or delegated to act, in that position.

**Disruptive Behaviour** means aberrant behaviour manifested through personal interaction with Medical Practitioners, hospital personnel, health care professionals, patients, family members, or others, which interferes with a patient's care, or could reasonably be expected to interfere with the process of delivering quality care or which is inconsistent with the values of Cura.

**Emergency Accreditation** means the process provided in these By-Laws whereby a Medical Practitioner, Dentist, Allied Health Professional, Nurse Practitioner or Podiatric Surgeon is Accredited for a specified short period on short notice in an emergency situation. Emergency Accreditation is not available to Perioperative Nurse Surgical Assistants.

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

**Fundamental Change** means any material modification, upgrade, or alteration to an AI system that:

- (a) significantly changes the AI system's core functionality, capabilities, or primary approved use case; training data or methodology in a way that alters outcomes or meaningfully changes system behaviour; or increases the system's overall risk level or potential impacts on stakeholders; or
- (b) involves deployment or use of the AI system in new ways or areas not previously approved; or the integration or interaction with new critical systems, populations, or data sources.

**Funder** refers to any Private Health insurer, DVA, Third Party Insurer, Department or Ministry of Health in each State or Territory (including any statutory Health Services).

**Government Agency** means any government or any public, statutory, governmental, semi-governmental, local governmental or judicial body, entity or authority and includes a Minister of the Crown or the Commonwealth of Australia and any person, body, entity, or authority exercising a power pursuant to an Act of Parliament.

**Hospital(s)** means a private day hospital owned and operated by Cura within Australia.

**Hospital CEO/Director of Nursing, CEO or Director of Nursing** means the person appointed to the position of Hospital CEO/Director of Nursing, or equivalent position by whatever name, of the Relevant Hospital or any person acting, or delegated to act, in that position.

**HREC** means Human Research Ethics Committees established in accordance with NHMRC Guidelines.

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

**Mandatory AI Training** means mandatory AI training in accordance with section 6 of the AI Use Policy.

**Medical Advisory Committee** means the Medical Advisory Committee (or equivalent) of the relevant Hospital.

**Medical Benefits Schedule (MBS)** is a listing of the Medicare services subsidised by the Australian Government and the associated fees.

**Medical Device** has the meaning given to it in the *Therapeutic Goods Act 1989* (Cth).

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

**Mutual Recognition** has the meaning given to it in clause 8.7.1.

**National Law** means *Health Practitioner Regulation National Law Act 2009* as in force in each State and Territory and as amended from time to time.

**NHMRC** means the National Health and Medical Research Council established in accordance with the *National Health and Medical Research Council Act 1992* (Cth).

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

**National Hospitals Operations Manager(s)** means the person(s) appointed to manage a cluster of Hospitals within an assigned geographical area, or any persons acting or delegated to act in that position, being the person(s) to whom Hospital CEO, DoN or CEO/DoN report to.

**Nurse Practitioner** means a Registered Nurse practising as a nurse practitioner, who has been credentialed and granted a Scope of Practice at the Relevant Hospital, and who is authorised to provide clinical services within that endorsed and Cura-approved Scope of Practice independently of, but not necessarily without collaboration with, a Medical Practitioner. A Nurse Practitioner is an Accredited Practitioner for the purposes of these By-Laws.

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

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

**Patient** means a person admitted to or treated as an outpatient at the relevant Hospital.

**Performance** means the extent to which an Accredited Practitioner provides, or has provided, health care services in a manner which is considered consistent with good and current Clinical Practice and results in expected patient benefits and outcomes. When considered as part of the

Accreditation process, Performance will include an assessment and examination of the provision of health care services over the prior periods of Accreditation (if any).

**Perioperative Nurse Surgical Assistant or PNSA** means a Registered Nurse who holds the postgraduate qualifications, training, and assessed competencies required under Cura's Credentialing and Scope of Practice of Health Professionals Policy to perform surgical first assisting functions within an operating theatre environment, who has been credentialed and granted a Scope of Practice at the Relevant Hospital, and who is authorised to provide surgical assisting services only within the Scope of Practice of, and under the direct or proximate supervision of, a credentialed and Accredited Medical Practitioner (Surgeon) at the same Relevant Hospital. A Perioperative Nurse Surgical Assistant is not an independent practitioner.

**Practitioner** means a Medical Practitioner, Dentist, Allied Health Professional or Advanced Practice Nurse.

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

**Registered Nurse** means a person registered as a Registered Nurse by the Nursing and Midwifery Board of Australia governed by AHPRA pursuant to the National Law as in force in each State and Territory.

**Relevant Hospital** means a hospital or facility within the Cura network of hospitals to which an application for Accreditation is made.

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

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

**State and Territory** means a state and territory of the Commonwealth of Australia.

**Surgical Assistant** means a Medical Practitioner Accredited under clause 8.8A to provide surgical assisting services at a Relevant Hospital within a defined Scope of Practice limited to surgical assisting under the supervision and direction of an Accredited Medical Practitioner (Surgeon).

**Temporary Accreditation** means the process provided in By-Laws whereby a Medical Practitioner, Dentist, Allied Health Professional or Nurse Practitioner is Accredited for a limited period. Temporary Accreditation is not available to Perioperative Nurse Surgical Assistants.

**The Eye Hospital** means the Cura facility at 262 Charles Street, Launceston, Tasmania 7250.

**Threshold Credentials** means the minimum credentials for each clinical service, procedure, or other intervention which applicants for Credentialing, within the Scope of Practice sought, are required to meet before any application will be processed and approved. Threshold credentials are to be approved by the Chief Executive Officer and may be incorporated into an Accreditation/Credentialing policy.

**Visiting Advanced Practice Nurse** means an Advanced Practice Nurse who is not an employee of the relevant Hospital and who has been granted Accreditation and Scope of Practice pursuant to these By-Laws.

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

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

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

**Visiting Podiatric Surgeon** means, for the purposes of these By-Laws, a person who is not an employee of the Relevant Hospital, who is registered as a podiatrist with specialist registration in podiatric surgery by the Podiatry Board of Australia and registered with AHPRA.

### 3.2 Interpretation

- (a) Headings in these By-Laws are for convenience only and are not to be used as an aid in interpretation.
- (b) In these By-Laws, unless the context makes it clear the rule of interpretation is not intended to apply, words importing the masculine gender will also include feminine gender, words importing the singular will also include the plural, if a word is defined another part of speech has a corresponding meaning, if an example is given the example does not limit the scope, and reference to legislation (including subordinate legislation or regulation) is to that legislation as amended, re-enacted or replaced.
- (c) The Chief Executive Officer, National Hospitals Operations Manager and Hospital CEO/Director of Nursing may delegate any of the responsibilities conferred upon him/her by the By-Laws in his/her complete discretion, but within any delegation parameters approved by the Board.
- (d) Any dispute or difference which may arise as to the meaning or interpretation or application of these By-Laws or as to the powers of any committee or the validity of proceedings of any meeting will be determined by the Chief Executive Officer. There is no appeal from such a determination by the Chief Executive Officer.

### 3.3 Meetings

- 3.3.1 Where a reference is made to a meeting, the quorum requirements that will apply are those specified in the terms of reference of the Relevant committee.
- 3.3.2 Committee resolutions and decisions, if not specified in the terms of reference, must be supported by a show of hands or ballot of committee members at the meeting.
- 3.3.3 Voting, if not specified elsewhere, will be on a simple majority voting basis and only by those in attendance at the meeting (including attendance by electronic means). There will be no proxy vote.
- 3.3.4 In the case of an equality of votes, the chairperson will have the casting vote.
- 3.3.5 A committee established pursuant to these By-Laws may hold any meeting by electronic means or by telephonic communication whereby participants can be heard.
- 3.3.6 Resolutions may be adopted by means of a circular resolution.

- 3.3.7 Information provided to any committee or person will be regarded as confidential and is not to be disclosed to any third party or beyond the purpose for which the information was made available.
- 3.3.8 Any member of a committee who has a conflict of interest or material personal interest in a matter to be decided or discussed must inform the chairperson of the committee and will be required to leave the meeting during any part of the meeting where the matter giving rise to the conflict is discussed.

## **4. Introduction**

### **4.1 Purpose of this document**

- 4.1.1 This document sets out the terms and conditions on which Medical Practitioners, Specialist Surgeons, Dentists, Allied Health Professionals may apply to be Accredited within the defined Scope of Practice granted, the basis upon which a successful applicant may admit Patients and/or care and treat Patients at Cura Hospitals and the terms and conditions for continued Accreditation.
- 4.1.2 The By-Laws apply to all Cura Hospitals.
- 4.1.3 Every applicant for Accreditation must review the By-Laws and Annexures before making an application. It is an expectation of Cura that the By-Laws are read in their entirety by the applicant as part of the application process. Ignorance of the By-Laws will not be regarded as an acceptable excuse.
- 4.1.4 Patient care is provided by Accredited Practitioners who have been granted access to use the relevant Hospital and its resources to provide that care. The By-Laws define the relationship and obligations between the relevant Hospital and its Accredited Practitioners.
- 4.1.5 The Relevant Hospital aims to maintain a high standard of patient care and to continuously improve the safety and quality of its services. The By-Laws implement measures aimed at maintenance and improvements in safety and quality.
- 4.1.6 Health care in Australia is regulated by legislation and standards. These By-Laws assist in compliance with certain aspects of Cura's regulatory obligations but is not a substitute for review of the relevant legislation and standards.

## **Part A — Terms and Conditions of Accreditation**

### **5. Compliance with By-Laws**

#### **5.1 General**

- 5.1.1 It is a requirement for continued Accreditation that Accredited Practitioners comply with the By-Laws at all relevant times when admitting, caring for or treating patients, or otherwise providing services at Cura facilities and hospitals.
- 5.1.2 Any non-compliance with the By-Laws may be a ground for suspension, investigation, termination, or imposition of conditions.
- 5.1.3 Unless specifically determined otherwise by the Chief Executive Officer in writing for a specified Accredited Practitioner, the provisions of these By-Laws in their entirety prevail to the extent of any inconsistency with any terms, expressed or implied, in a contract of employment or engagement that may be entered into.

5.1.4 In the absence of a specific written determination by the Chief Executive Officer, it is a condition of ongoing Accreditation that the Accredited Practitioner agrees that the provisions of these By-Laws prevail to the extent of any inconsistency or uncertainty between the provisions of these By-Laws and any terms, express or implied, in a contract or employment or engagement.

## **5.2 Compliance with policies and procedures**

5.2.1 Accredited Practitioners must comply with all policies and procedures in place at the Relevant Hospital and Cura, including but not limited to the AI Governance Framework and AI Use Policy.

## **5.3 Compliance with legislation**

5.3.1 Accredited Practitioners must comply with all relevant legislations, including but not limited to legislations that relates to health, immunisation, public health, drugs and poisons, privacy, coroners, criminal law, health practitioner registration, research, clinical trials, environmental protection, workplace health & safety, occupational health and safety, anti-discrimination, bullying, harassment, industrial relations, care of children, care of persons with a disability, substituted decision making and persons with impaired capacity, mental health, Medicare, health insurance, competition and consumer law, privacy laws, intellectual property, and other Relevant legislation regulating the Accredited Practitioner, provision of health care or impacting upon the operation of Cura and the Relevant Hospital.

5.3.2 In addition, Accredited Practitioners must ensure compliance with, or assist the Relevant Hospital to comply with, any Commonwealth or State mandated service capability frameworks or minimum standards.

## **5.4 Insurance and registration**

5.4.1 Accredited Practitioners must at all times maintain Adequate Professional Indemnity insurance.

5.4.2 Accredited Practitioners must at all times maintain registration with their Relevant National Board that is sufficient for the Scope of Practice granted.

5.4.3 Accredited Practitioners are required to provide evidence annually, or at other times upon request, of Adequate Professional Indemnity Insurance and registration, and all other relevant licences or registration requirements for the Scope of Practice granted. If further information is requested in relation to insurance or registration, the Accredited Practitioner will assist to obtain that information or provide permission for the Relevant Hospital to obtain that information directly.

## **5.5 Standard of conduct**

5.5.1 Cura expects a high standard of professional and personal conduct from Accredited Practitioners, who must conduct themselves in accordance with:

- (a) the Behavioural Standards;
- (b) the Code of Ethics of the Australian Medical Association or any other Relevant Code of Ethics;
- (c) the Code of Practice of any specialist college or professional body of which the Accredited Practitioner is a member;
- (d) the Values of Cura;
- (e) the strategic direction of Cura and the Relevant Hospital;
- (f) the limits of their registration or any conditions placed upon Scope of Practice in accordance with these By-Laws;

- (g) when using AI systems, the AI Governance Framework, AI Core Values, and AI Use Policy; and
- (h) all reasonable requests made with regard to personal conduct in the Relevant Hospital.

5.5.2 Accredited Practitioners must continuously demonstrate Competence and Current Fitness, must not engage in Disruptive Behaviour, and must observe all reasonable requests with respect to conduct and behaviour.

5.5.3 Accredited Practitioners must not engage in any conduct that may be perceived as a reprisal against another person for making a report or supplying information relating to the Behavioural Standards.

5.5.4 Upon request by the Chief Executive Officer, the National Hospitals Operations Manager or Hospital CEO/Director of Nursing, the Accredited Practitioner is required to meet with either or all of them to discuss matters in 5.5.1 to 5.5.3 above, or any other matter arising out of these By-Laws.

## 5.6 Notifications

5.6.1 Accredited Practitioners must immediately advise the Hospital CEO/Director of Nursing, and follow up with written confirmation within two (2) business days, should:

- (a) an investigation or complaint be commenced in relation to the Accredited Practitioner, or about his/her Patient (irrespective of whether this relates to a Patient of the Relevant Hospital), by AHPRA, the Accredited Practitioner's registration board, disciplinary body, Coroner, a health complaints body, or another statutory authority, State or Territory Government agency;
- (b) an adverse finding (including but not limited to a reprimand, criticism or adverse comment about the care or services provided by the Accredited Practitioner) be made against the Accredited Practitioner by a civil court, AHPRA, the practitioner's registration board, disciplinary body, Coroner, a health complaints body, or another statutory authority, State or Government agency, irrespective of whether this relates to a Patient of the Relevant Hospital;
- (c) the Accredited Practitioner's professional registration be revoked or amended, or should conditions be imposed, or should undertakings be agreed, irrespective of whether this relates to a Patient of the Relevant Hospital and irrespective of whether this is noted on the public register or is privately agreed with a registration board;
- (d) professional indemnity membership or insurance be made conditional or not be renewed, or should limitations be placed on insurance or professional indemnity coverage;
- (e) the Accredited Practitioner's appointment, clinical privileges or Scope of Practice at any other facility, hospital or day procedure centre, altered in any way, including through resignation or if it is withdrawn, suspended, restricted, or made conditional, and irrespective of whether this was done by way of agreement;
- (f) any physical or mental condition or substance abuse problem occur that could affect his or her ability to practise or that would require any special assistance to enable him or her to practise safely and competently;

- (g) the Accredited Practitioner believe that Patient care or safety is being compromised or at risk, or may potentially be compromised or at risk, by another Accredited Practitioner of the Relevant Hospital;
- (h) the Accredited Practitioner make a mandatory notification to a health practitioner registration board in relation to another Accredited Practitioner of the Relevant Hospital; and
- (i) the Accredited Practitioner be charged with having committed or is convicted of a sex, violence, physical harm, psychological harm, child related or other criminal offence. The Accredited Practitioner must provide the Relevant Hospital with an authority to conduct at any time, a criminal history check with the appropriate authorities.

5.6.2 If the Accredited Practitioner becomes aware of or has reasonable grounds to suspect a conditional licence holder or member of personnel has breached the AI Use Policy, the Accredited Practitioner must make a report to the Head of IT.

5.6.3 In addition, Accredited Practitioners should inform themselves of their personal obligations in relation to external notifications and ensure compliance with these obligations, including for example, as a member of a Medical Advisory Committee in New South Wales pursuant to the *Private Health Hospitals Act 2007* (NSW) or mandatory reporting to AHPRA. Cura expects the Accredited Practitioner to comply with these obligations.

## 5.7 Continuous disclosure

5.7.1 The Accredited Practitioner must keep the Hospital CEO/Director of Nursing continuously informed of every fact and circumstances which has, or will likely have, a material bearing upon:

- (a) the Accreditation of the Accredited Practitioner;
- (b) the Scope of Practice of the Accredited Practitioner;
- (c) the ability of the Accredited Practitioner to safely deliver health services to his/her Patients within the Scope of Practice, including if the Accredited Practitioner suffers from an illness or disability which may adversely affect his or her Current Fitness;
- (d) the Accredited Practitioner's registration or professional indemnity insurance arrangements;
- (e) the inability of the Accredited Practitioner to satisfy a medical malpractice claim by a Patient;
- (f) adverse outcomes or complications that result in injury, disability or harm in relation to the Accredited Practitioner's Patients (current or former) of the Relevant Hospital;
- (g) complaints, compensation claims, reportable deaths and coronial investigations in relation to the Accredited Practitioner's Patients (current or former) of the Relevant Hospital;
- (h) matters set out in By-law 5.6;
- (i) the reputation of the Accredited Practitioner as it relates to the provision of Clinical Practice; and
- (j) the reputation of the Relevant Hospital and Cura.

5.7.2 Subject to restrictions directly relating to or impacting upon legal professional privilege or statutory obligations of confidentiality, every Accredited Practitioner must keep the Hospital

CEO/Director of Nursing informed and updated about the commencement, progress and outcome of compensation claims, coronial investigations or inquests, police investigations, Patient complaints, health complaints body complaints or investigations, or other inquires involving Patients of the Accredited Practitioner that were treated at the Relevant Hospital.

## 5.8 Representations and media

- 5.8.1 Unless an Accredited Practitioner has the prior written consent of the Chief Executive Officer or the National Hospitals Operations Manager, an Accredited Practitioner must not use Cura or Relevant Hospital's name, logo and/or letterhead, or in any way suggest that the Accredited Practitioner represents these entities.
- 5.8.2 The Accredited Practitioner must obtain the Chief Executive Officer's prior approval before interaction with the media regarding any matter involving the Relevant Hospital, Cura or a Patient.

## 5.9 Committees

The Relevant Hospital requires Accredited Practitioners, as reasonably requested by the Hospital CEO/Director of Nursing, to assist it in achieving its objectives through membership of committees of Cura and/or the Relevant Hospital. This includes committees responsible for developing, implementing, and reviewing policies in all clinical areas; the AI Governance Council; participating in medical, nursing, and other education programs and attending meetings of Medical Practitioners, Dentists and/or Allied Health Professionals.

## 5.10 Confidentiality

- 5.10.1 Accredited Practitioners will manage all matters relating to the confidentiality of information in compliance with Cura's policies and the 'Australian Privacy Principles' established by the *Privacy Act 1988 (Cth)*, and other legislation and regulations relating to privacy and confidentiality and will not do anything to bring Cura in breach of these obligations.
- 5.10.2 Accredited Practitioners must comply with the various legislation governing the collection, handling, security, storage, and disclosure of health information, as well as notification of data breaches.
- 5.10.3 Accredited Practitioners will comply with common law duties of confidentiality.
- 5.10.4 The following will be kept confidential by Accredited Practitioners:
- (a) Commercial in confidence business information concerning Cura;
  - (b) The particulars of these By-Laws;
  - (c) Information concerning Cura's insurance arrangements;
  - (d) Information concerning any Patient or staff of a Relevant Hospital or Cura;
  - (e) Information which comes to their knowledge concerning Patients, Accredited Practitioners, Clinical Practice, quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services, including from membership of or participation in Relevant Hospital committees.
- 5.10.5 In addition to statutory or common law exceptions to confidentiality, the confidentiality requirements do not apply in the following circumstances:
- (a) where disclosure is required to provide continuing care to the Patient;
  - (b) where disclosure is required by law;

- (c) where disclosure is made to a regulatory or registration body in connection with the Accredited Practitioner, another Accredited Practitioner, the Relevant Hospital, or Cura;
- (d) where the person benefiting from the confidentiality consents to the disclosure or waives the confidentiality; or
- (e) where disclosure is required in order to perform some requirement of these By-Laws.

5.10.6 Accredited Practitioners must also comply with the AI Use Policy with respect to the use of AI systems in connection with confidential information, personal information, and health information.

5.10.7 The confidentiality requirements continue with full force and effect after the Accredited Practitioner ceases to be Accredited.

## **5.11 Communication within Cura**

5.11.1 Accredited Practitioners are required to familiarise themselves with the organisational structure of Cura.

5.11.2 Accredited Practitioners acknowledge that in order for the organisation to function, effective communication is required, including between the Hospital CEO/Director of Nursing, Director of Nursing, Committees of the Relevant Hospital and its staff, Board, Chief Executive Officer, National Hospitals Operations Manager, Executive Management Committee and Cura staff.

5.11.3 Accredited Practitioners acknowledge and consent to communication between these persons and entities of information, including their own personal information, that may otherwise be restricted by the Privacy Laws. The acknowledgement and consent are given on the proviso that the information will be dealt with in accordance with obligations pursuant to Privacy Laws and only for proper purposes and functions.

## **6. Safety and quality**

### **6.1 Admission, availability, communication, & discharge**

6.1.1 Visiting Medical Practitioners, Visiting Dentists, Visiting Allied Health Professionals and Podiatric Surgeons will admit (if applicable) and treat Patients at the Relevant Hospital on a regular basis and be an active provider of services at the Relevant Hospital.

6.1.2 Visiting Medical Practitioners or Visiting Dentists who admit Patients to the Relevant Hospital for treatment and care must ensure that they are available to treat and care for those Patients at all times, or failing that, that other arrangements as permitted by the By-Laws are put in place to ensure the continuity of treatment and care for those Patients. Visiting Allied Health Professionals who treat Patients must ensure they are available to treat and care for those Patients at all times or ensure continuity for treatment and care.

6.1.3 Accredited Practitioners must visit all Patients admitted or required to be treated by them as frequently as is required by the clinical circumstances of those Patients and as would be judged appropriate by professional peers.

6.1.4 An Accredited Practitioner will be contactable to review the Patient in person, or their on-call or locum cover is available as requested by nursing staff to review the Patient in the Relevant Hospital. If locum or back-up cover is not available to attend and review the Patient, this must be immediately notified to the Hospital CEO/Director of Nursing.

- 6.1.5 Accredited Practitioners must ensure that all reasonable requests by Relevant Hospital staff are responded to in a timely manner and in particular, Patients are promptly attended to when reasonably requested by Relevant Hospital staff for clinical reasons. If Accredited Practitioners are unable to provide this level of care personally, he/she will secure the agreement of another Accredited Practitioner to provide the care and treatment and will advise the staff of the Relevant Hospital of this arrangement. If locum or back-up cover is not available to attend and review the Patient, this must be immediately notified to the Hospital CEO/Director of Nursing.
- 6.1.6 Accredited Practitioners must be available and attend upon Patients of the Accredited Practitioner in a timely manner when requested by Relevant Hospital staff or be available by telephone in a timely manner to assist Relevant Hospital staff in relation to the Accredited Practitioner's Patients. Alternatively, the Accredited Practitioner will make arrangements with another Accredited Practitioner to assist or will put in place, with prior notice, appropriate arrangements in order for another Accredited Practitioner to assist and will advise the staff of the Relevant Hospital of this arrangement. If locum or back-up cover is not available to attend and review the Patient, this must be immediately notified to the Hospital CEO/Director of Nursing.
- 6.1.7 It is the responsibility of the Accredited Practitioner to ensure any changes to contact details are notified promptly to the Hospital CEO/Director of Nursing. Accredited Practitioners must ensure that their communication devices are functional and that appropriate alternative arrangements are in place to contact them if their communication devices need to be turned off for any reason.
- 6.1.8 A locum must be approved in accordance with these By-Laws and the Accredited Practitioner must ensure that the locum's contact details are made available to the Relevant Hospital and all Relevant persons are aware of the locum cover and the dates of locum cover.
- 6.1.9 Accredited Practitioners must only treat Patients within the Scope of Practice granted.
- 6.1.10 Accredited Practitioners are required to work with and as part of a multi-disciplinary health care team, including effective communication – written and verbal, to ensure the best possible care for Patients. Accredited Practitioners must at all times be aware of the importance of effective communication with other members of the health care team, referring doctors, the Relevant Hospital executive, Patients and the Patient's family or next of kin, and at all times ensure appropriate communication has occurred, adequate information has been provided, and questions or concerns have been adequately responded to.
- 6.1.11 The Accredited Practitioner must appropriately supervise the care that is provided by the Relevant Hospital staff and other practitioners. This includes providing adequate instructions to, and supervision of, Relevant Hospital staff to enable staff to understand what care the Accredited Practitioner requires to be delivered.
- 6.1.12 Adequate instructions and clinical handover is required to be given to the Relevant Hospital staff and other practitioners (including their on-call and locum cover) to enable them to understand what care the Accredited Practitioner requires to be delivered. The Accredited Practitioner must appropriately supervise the care that is provided by the Relevant Hospital staff and other practitioners.

- 6.1.13 If care is transferred to another Accredited Practitioner, this must be noted on the Patient medical record and communicated to the Director of Nursing or other responsible nursing staff member.
- 6.1.14 Accredited Practitioners must give consideration to their own potential fatigue and that of other staff involved in the provision of patient care, when making patient bookings and in utilising operating theatre and procedure room time;
- 6.1.15 Where on-call arrangements are in place, Accredited Practitioners must participate in formal on-call arrangements as reasonably required by the Relevant Hospital. Persons providing on-call or cover services must be Accredited at the Relevant Hospital.
- 6.1.16 The Accredited Practitioner must ensure that their Patients are not discharged without the approval of the Accredited Practitioner, complying with the discharge policy of the Relevant Hospital and completing all Patient discharge documents required by the Relevant Hospital. It is the responsibility of the Accredited Practitioner to ensure all information reasonably necessary to ensure continuity of care after discharge is provided to the referring practitioner, general practitioner, or other treating practitioner.

## **6.2 Surgery**

- 6.2.1 Accredited Practitioners must effectively utilise allocated theatre sessions that have been requested by the Accredited Practitioner.
- 6.2.2 Accredited Practitioners acknowledge the importance of, and will strictly adhere to, various measures aimed at ensuring safety and quality during surgery, which includes but is not limited to participating in or allowing to occur procedures relating to correct site surgery, team time out, infection control and surgical item counts.
- 6.2.3 An Accredited Practitioner must not use, aid, or facilitate the use of a surgical or procedural assistant at the Relevant Hospital who does not hold current Accreditation at the Relevant Hospital as a Perioperative Nurse Surgical Assistant or Surgical Assistant under these By-Laws. For the avoidance of doubt, a Perioperative Nurse Surgical Assistant who holds current Accreditation under clause 15A and who is acting within their approved Scope of Practice satisfies this requirement, and a Surgical Assistant who holds current Accreditation under clause 8.8A and who is acting within their approved Scope of Practice satisfies this requirement.

## **6.3 Facility, State-Based and National Safety Programs, Initiatives and Standards**

- 6.3.1 Accredited Practitioners acknowledge the importance of ongoing safety and quality initiatives that may be instituted by Cura and the Relevant Hospital based upon its own safety and quality program, or safety and quality initiatives, programs or standards of State or Commonwealth health departments, statutory bodies or safety and quality organisations (including for example the Australian Commission on Safety and Quality in Health Care, a State based division of a Health Department such as the Office of Patient Safety and Clinical Quality in Western Australia, or a State based independent statutory body).
- 6.3.2 Accredited Practitioners will participate in and ensure compliance with these initiatives and programs (including if they are voluntary initiatives that the Relevant Hospital elects to participate in or undertake), whether these apply directly to the Accredited Practitioner or are imposed upon the Relevant Hospital and require assistance from the Accredited Practitioner to ensure compliance, including but not limited to the National Safety and

Quality Health Service Standards and Clinical Care Standards of the Australian Commission on Safety and Quality in Health Care.

#### **6.4 Treatment and financial consent**

- 6.4.1 Accredited Practitioners must obtain fully informed consent for treatment (except where it is not practical in cases of emergency) from the Patient or their legal guardian or substituted decision maker in accordance with accepted medical and legal standards and in accordance with the policy and procedures of the Relevant Hospital. For the purposes of this provision, an emergency exists where immediate treatment is necessary in order to save a person's life or to prevent serious injury to a person's health.
- 6.4.2 The consent will be evidenced in writing and signed by the Accredited Practitioner and Patient or their legal guardian or substituted decision maker.
- 6.4.3 It is expected that fully informed consent will be obtained by the Accredited Practitioner under whom the Patient is admitted or treated, in accordance with the Medical Practitioner's / Dentist's non-delegable duty of care. The Accredited Practitioner will use our Cura Patient Consent Form, provided by Cura, and as amended from time to time. The consent process will ordinarily include an explanation of the Patient's condition and prognosis, treatment, and alternatives, inform the Patient of material risks associated with treatment and alternatives, and then obtain the consent to treatment. The consent process must also satisfy the Relevant Hospital's requirements from time to time as set out in its policy and procedures.
- 6.4.4 Accredited Practitioners must provide full financial disclosure and obtain fully informed financial consent from their Patients in accordance with the Relevant legislation, health fund agreements, policy and procedures of the Relevant Hospital.
- 6.4.5 Accredited Practitioners must not invoice any patients for items such as Prostheses, Consumables or any other items that are considered covered or bundled under the hospital's agreement with the Funder. Unless prior approval is granted by Cura's CEO or delegate, Accredited Practitioners must not supply their own Prostheses or consumables for a procedure.

#### **6.5 Patient Records**

- 6.5.1 Accredited Practitioners must ensure that:
- (a) Patient records held by the Relevant Hospital are adequately maintained for patients treated by the Accredited Practitioner;
  - (b) Patient records satisfy Cura and Relevant Hospital policy requirements, legislative requirements, the content and standard required by the Australian Commission on Safety and Quality in Health Care, accreditation requirements, and health fund obligations;
  - (c) they maintain full, accurate, legible and contemporaneous medical records, including in relation to each attendance upon the patient, with the entries dated, time and signed;
  - (d) they comply with all legal requirements and standards in relation to the prescription and administration of medication, and properly document all drugs ordered clearly and legibly in the medication chart maintained by the Relevant Hospital;
  - (e) Patient records include all Relevant information and documents reasonably necessary to allow Relevant Hospital staff and other Accredited Practitioners to care for patients;

- (f) Where an Accredited Practitioner uses an AI system to create, edit, access, or generate a Patient record, the Accredited Practitioner must comply with the AI Use Policy, including:
  - (A) ensuring the AI system is listed on the Approved AI System Register and approved for use in connection with patient records and personal information;
  - (B) satisfying themselves that Cura holds appropriate informed consent from the Patient for the input of personal information in the AI system;
  - (C) remaining professionally responsible for AI system output and use; and
  - (D) reviewing and verifying all AI system output before incorporating it into a Patient record.
- (g) A procedure report is completed, including a detailed account of the findings, technique undertaken, complications, and post-procedure orders;
- (h) An anaesthetic report is completed, as well as documentation evidencing fully informed anaesthetic consent and post-anaesthetic evaluation;
- (i) A discharge summary is completed that includes all Relevant information reasonably required by the referring practitioner, general practitioner, or other treating practitioner for ongoing care of the Patient.

## **6.6 Financial information and statistics**

- 6.6.1 Accredited Practitioners must record all data required by the Relevant Hospital to meet health fund obligations, collect revenue, and allow compilation of health care statistics.
- 6.6.2 Accredited Practitioners must ensure that all Pharmaceutical Benefits Scheme prescription requirements and financial certificates are completed in accordance with Relevant Hospital policy and regulatory requirements. Accredited Practitioners must provide provisional Medicare Benefit Schedule (MBS) item numbers at time of patient booking.
- 6.6.3 Accredited Practitioners must ensure that final MBS is documented, where appropriate, at the end of the procedure. Where pathology is sent for investigation (and may alter the MBS), the final MBS are provided as soon as pathology results are received.
- 6.6.4 Accredited Practitioners must ensure that valid certification is provided for any patient admitted for an MBS that is listed in the Private Health Insurance (Benefit Requirements) Rules 2011 as a Type B or Type C procedure.

## **6.7 Quality improvement, risk management and regulatory agencies**

- 6.7.1 Accredited Practitioners are required to attend and participate in the Relevant Hospital's safety, quality, risk management, education and training activities, including clinical practice review and peer review activities, and as required by Relevant legislation, standards and guidelines (including those standards and guidelines set by Relevant Commonwealth or State governments, health departments or statutory health organisations charged with monitoring and investigating safety and quality of health care). This includes a requirement to meaningfully participate in clinical review and peer review committee meetings, including review of clinical data and outcomes and respond to requests for information regarding statistical outliers, adverse events and cases flagged in incidents, clinical indicator or key performance indicator reporting.
- 6.7.2 Accredited Practitioners will report to the Relevant Hospital incidents, complications, adverse events, deaths and complaints (including in relation to the Accredited Practitioner's

patients) in accordance with the Relevant Hospital policy and procedures and where required by the Hospital CEO/Director of Nursing will assist with incident management, investigation and reviews (including root cause analysis and other systems reviews), complaints management and open disclosure processes.

- 6.7.3 Accredited Practitioners will participate in risk management activities and programs, including the implementation by the Relevant Hospital of risk management strategies and recommendations from system reviews, and will maintain and comply with the ongoing minimum competency and continuing professional development requirements of their professional college with respect to the approved Scope of Practice.
- 6.7.4 Accredited Practitioners must provide all reasonable and necessary assistance in circumstances where the Relevant Hospital requires assistance from the Accredited Practitioner in order to comply with or respond to a legal request or direction, including for example where that direction is pursuant to a court order, or from a health complaints body, AHPRA, Coroner, Police, State Health Department and its agencies or departments, Private Health Unit, and Commonwealth Government and its agencies or departments.
- 6.7.5 Accredited Practitioners must comply with and take all reasonable actions to assist the Relevant Hospital to comply with, each of the National Safety and Quality Health Service Standards issued by the Australian Commission on Safety and Quality in Health Care and any associated clinical guidelines.

## **6.8 Clinical speciality committees**

- 6.8.1 Cura or the Hospital CEO/Director of Nursing may establish clinical speciality committees for the purpose of reviewing and advising Cura or the Hospital CEO/Director of Nursing on performance of the clinical speciality by reference to the Relevant Hospital's clinical services, Organisational Capability and Organisational Need. These committees may include but are not limited to peer review and quality activities.
- 6.8.2 Each clinical speciality committee, in consultation with the Hospital CEO/Director of Nursing, will establish terms of reference for the committee and will report annually, or as required by the Hospital CEO/Director of Nursing, on its activities to the Medical Advisory Committee, and make recommendations to the Medical Advisory Committee on issues Relevant to the clinical speciality.

## **6.9 Participation in clinical teaching activities**

- 6.9.1 Accredited Practitioners, if requested, are required to reasonably participate in the Relevant Hospital's clinical teaching program.

## **6.10 AI systems**

- 6.10.1 Prior to using any AI system for or in connection with Cura, Accredited Practitioners must:
  - (a) read and understand the AI Governance Framework, AI Core Values, and AI Use Policy;
  - (b) confirm both the AI system and specific use case are listed on the Approved AI System Register;
  - (c) satisfy themselves that Cura holds appropriate informed consent for the input of personal information into the AI system;
  - (d) be up to date with appropriate AI training, including any applicable Mandatory AI Training; and

- (e) exercise critical judgment about whether use of the AI system is appropriate in the context of the specific task, taking into account how the AI system works (high level understanding), its limitations, and how the individual Accredited Practitioner will maintain adequate oversight of AI output.

6.10.2 If an Accredited Practitioner would like to use an AI system that is not listed on the AI System Register, the Accredited Practitioner must contact their Head of Department, Hospital CEO, or Director of Nursing to request that an application be made to the AI Governance Council in accordance with the AI Governance Framework. The AI system must not be used until such time it is approved for Pilot or listed on the Approved AI System Register.

6.10.3 If Accredited Practitioners have been notified of or are aware of any concerns (e.g. from Patients) about the use of AI systems, Accredited Practitioners must promptly notify the Head of IT.

## **6.11 Research**

6.11.1 Any research, including a HREC approved clinical trial, must not be conducted at the Relevant Hospital without the prior written approval of the Cura Executive Management Committee (**EMC**), such approval being at the EMC's absolute discretion.

6.11.2 The Accredited Practitioner must submit in writing to the Hospital CEO and/or DoN of the Relevant hospital, the following material to provide to EMC:

- (a) Information regarding the nature of the proposed research clinical trial;
- (b) Name and contact information of the sponsor (if clinical trial);
- (c) Study documents, including but not limited to the Study Protocol (if applicable);
- (d) HREC approval (if applicable);
- (e) A copy of consent information and participant consent form (including draft);
- (f) A copy of the Clinical Research Trial Agreement or such other agreement (including a draft);
- (g) A copy of third party indemnity (including draft) and/or evidence of insurance; and
- (h) Any other material required by the EMC for the EMC to make its decision.

6.11.3 The activities to be undertaken in the research must fall within the Scope of Practice of the Accredited Practitioner.

6.11.4 For aspects of the research falling outside a third-party indemnity (including the exceptions listed in the indemnity), the Accredited Practitioner must have in place adequate insurance with a reputable insurer to cover the medical research.

6.11.5 Research will be conducted in accordance with NHMRC requirements, as amended and updated from time to time, and other applicable legislation.

6.11.6 An Accredited Practitioner has no power to bind Cura to a research project (including a clinical trial) by executing a research agreement.

6.11.7 There is no right of appeal from a decision by the EMC to reject an application for research.

## **6.12 Obtain written approval for New Clinical Services**

6.12.1 Before treating patients with New Clinical Services, an Accredited Practitioner is required to obtain the prior written approval of the Hospital CEO/Director of Nursing and what is

proposed must fall within the Accredited Practitioner's Scope of Practice or an amendment to the Scope of Practice has been obtained. For clarity, where a New Clinical Service involves the use of an AI system (including an AI system incorporated into a Medical Device), the Accredited Practitioner must also confirm in writing to the Hospital CEO/ Director of Nursing that the AI system is listed on the Approved AI System Register. If:

(a) the AI system or use case is not listed on the Approved AI System Register; or

(b) the New Clinical Service constitutes a Fundamental Change to an AI system,

the Accredited Practitioner must notify the Hospital CEO/ Director of Nursing of the same and must not use the AI system until such time the AI system, use case, or Fundamental Change is approved for Pilot or listed on the Approved AI System Register.

6.12.2 The Accredited Practitioner must provide evidence of Adequate Professional Indemnity Insurance to cover the New Clinical Service, and if requested, evidence that private health funds will adequately fund the New Clinical Services.

6.12.3 The Accredited Practitioner must provide progress reports, at intervals set out in the written approval, to the Hospital CEO/Director of Nursing of the Relevant Hospital, who will include the progress reports in briefing material for the Medical Advisory Committee and must comply with any subsequent directions received from the Hospital CEO/Director of Nursing of the Relevant Hospital (who will consult with the Chairperson of the Medical Advisory Committee).

6.12.4 If research is involved, then clause 6.11 must be complied with.

6.12.5 The Relevant Hospital CEO/Director of Nursing's decision is final and there will be no right of appeal from denial of requests for New Clinical Services.

### **6.13 Utilisation**

Accredited Practitioners will be advised upon Accreditation or Re-Accreditation, or at other times as determined by the Hospital CEO/Director of Nursing, of the expectations in relation to exercising Accreditation and utilisation of the facility. Absent special circumstances, the Accredited Practitioner must exercise Accreditation or utilise the facility in accordance with the specified expectations.

### **6.14 Students**

6.14.1 An Accredited Practitioner may be accompanied by a student provided that the following requirements are complied with:

- (a) The student must be enrolled to undertake training at a recognised tertiary institution, and the Accredited Practitioner is responsible for verifying that enrolment;
- (b) The student must have the prior approval of the Hospital CEO/Director of Nursing to attend the Relevant Hospital and supply any requested information or documents;
- (c) The Accredited Practitioner must provide effective and adequate supervision of the student at all times;
- (d) The student is not permitted to perform any direct clinical services upon or provide clinical care to a patient;
- (e) The Accredited Practitioner must seek the consent of the patient for the attendance of the student and clearly inform the Patient that the status of the individual is a student.

6.14.2 The student must comply with any direction or requirement of the Hospital CEO/Director of Nursing, as well as the policies and procedures of the Relevant Hospital.

## **Part B— Accreditation of Medical Practitioners**

### **7. Credentialing and Scope of Practice**

#### **7.1 Eligibility for Accreditation as Medical Practitioners**

Accreditation as Medical Practitioners will only be granted if Medical Practitioners demonstrate adequate Credentials, are professionally Competent, satisfy the requirements of the By-Laws, and are prepared to comply with the By-Laws, the Code of Conduct for Workers and Cura, AI Use Policy, and Relevant Hospital policies, and provide written acknowledgement/ticking the appropriate box on the application form of such preparedness.

#### **7.2 Entitlement to treat patients at the Relevant Hospital**

7.2.1 Medical Practitioners who have received Accreditation pursuant to the By-Laws are entitled to make a request for access to the hospital for the treatment and care of their patients within the limits of the defined Scope of Practice attached to such Accreditation at the Relevant Hospital and to utilise the services provided by the Relevant Hospital for that purpose, subject to the provisions of the By-Laws, Cura and Relevant Hospital policies, resource limitations, and in accordance with Organisational Need and Organisational Capability.

7.2.2 The decision to grant access to the Relevant Hospital for the treatment and care of a Medical Practitioner's patients is, on each occasion, within the sole discretion of the Hospital CEO/Director of Nursing and the grant of Accreditation contains no conferral of a general expectation of or 'right of access'.

7.2.3 A Medical Practitioner's use of the Relevant Hospital's services for the treatment and care of patients is limited to the Scope of Practice granted by the Hospital CEO/Director of Nursing and subject to the conditions upon which the Scope of Practice is granted, resource limitations, and Organisational Need and Organisational Capability. Accredited Practitioners acknowledge that admission or treatment of a particular Patient is subject always to bed availability, the availability or adequacy of nursing or allied health staff or Hospitals given the treatment or clinical care proposed.

#### **7.3 Responsibility and basis for Accreditation and granting of scope of practice**

The Hospital CEO/Director of Nursing will determine the outcome of applications for Accreditation as Medical Practitioners and defined Scope of Practice for each applicant. In making any determination, the Hospital CEO/Director of Nursing will make independent and informed decisions and, in so doing, will have regard to the matters set out in these By-Laws and will have regard to the recommendations of the Medical Advisory Committee. The Hospital CEO/Director of Nursing may, at his/her discretion, consider other matters as Relevant to the application when making his/her determination.

#### **7.4 Medical Advisory Committee**

7.4.1 The Hospital CEO/Director of Nursing will convene a Medical Advisory Committee (MAC) in accordance with the terms of reference established for the MAC.

7.4.2 The MAC members, including the chairperson, will be appointed by the Hospital CEO/Director of Nursing for such period as determined by the Hospital CEO/Director of Nursing and may be removed from membership of the committee by the Hospital CEO/Director of Nursing.

- 7.4.3 The Hospital CEO/Director of Nursing may establish a Credentialing Committee, which will be a sub-committee of the MAC. The Credentialing Committee will function in accordance with the terms of reference established for that committee. The primary role of a Credentialing Committee will be to conduct some aspects of the Credentialing requirements set out in these By-Laws and make recommendations to the MAC. In the event a Credentialing Committee is established, the responsibilities set out in these By-Laws in relation to Credentialing will still ultimately remain with the MAC.
- 7.4.4 In the absence of a Credentialing Committee, the role will be performed by the MAC. If the jurisdiction in which the Relevant Hospital is located requires a separate Credentialing Committee to consider and make recommendations relating to Credentialing, but the role is performed by the MAC, the terms of reference for the Credentialing Committee will include a process that provides for closing the MAC meeting and reconvening it as a Credentialing Committee meeting, including recording of separate minutes.
- 7.4.5 In addition to the terms of reference established for the MAC or Credentialing Committee, the Committees must be constituted according to, and the members of the Committees must conduct themselves in accordance with any legislative obligations, including standards that have mandatory application to the Facility and Committee members. For example, the obligations imposed pursuant to the Private Health Hospitals Act (NSW).
- 7.4.6 Members of the EMC and Hospital CEO/Director of Nursing will be entitled to attend meetings of the MAC as ex officio members, such that they will not have an entitlement to vote in relation to decisions or recommendations of the MAC and Credentialing Committee.
- 7.4.7 In making determinations about applications for Accreditation, there will ordinarily be at least one member of the same speciality as the applicant on the MAC, which may mean co-opting a committee member in order to assist with the determination. It is, however, recognised that this may not always be possible or practicable in the circumstances, and a failure to do so will not invalidate the recommendation of the MAC.

## **8. The process for appointment and re-appointment**

### **8.1 Applications for Initial Accreditation and Re-Accreditation as Medical Practitioners**

- 8.1.1 Applications for Initial Accreditation (where the applicant does not currently hold Accreditation at the Relevant Hospital) and Re-Accreditation (where the applicant currently holds Accreditation at the Relevant Hospital) as Medical Practitioners must be made via Cura's electronic credentialling system on the prescribed form. All questions on the prescribed form must be fully completed, and all required information and documents supplied before an application will be considered. Applications should be forwarded to the Cura Credentialling Delegate at least six weeks prior to the Medical Practitioner seeking to commence at the Relevant Hospital or such shorter time permitted by the Hospital CEO/Director of Nursing due to Organisational Need or patient needs. Temporary Accreditation or Emergency Accreditation will be considered at the discretion of the Hospital CEO/Director of Nursing.
- 8.1.2 Applications must include a declaration signed by the Medical Practitioner to the effect that the information provided by the Medical Practitioner is true and correct, that the Medical Practitioner will comply in every respect with the By-Laws and the Code of Conduct in the event that the Medical Practitioner's application for Accreditation is approved.
- 8.1.3 The Hospital CEO/Director of Nursing may interview and/or request further information from applicants that the Hospital CEO/Director of Nursing considers appropriate.

8.1.4 The Hospital CEO/Director of Nursing will ensure that applications are complete and requests for further information complied with, and upon being satisfied, will refer applications, together with notes from any interview conducted, to the Medical Advisory Committee (**MAC**) for consideration.

## **8.2 Consideration by the Medical Advisory Committee**

8.2.1 The MAC will consider all applications for Accreditation and Re-Accreditation referred to it by the Hospital CEO/Director of Nursing.

8.2.2 Consideration by the MAC will include, but not be limited to, information Relevant to Credentials, Competence, Current Fitness, Organisational Capability and Organisational Need.

8.2.3 The MAC will make recommendations to the Hospital CEO/Director of Nursing as to whether the applications should be approved and if so, on what terms, including the Scope of Practice to be granted.

8.2.4 The MAC will act and make recommendations in accordance with its terms of reference and any Relevant policy, as amended from time to time, including in relation to the consideration of applications for Accreditation and Re-Accreditation.

8.2.5 In instances where the MAC has doubts about a Medical Practitioner's ability to perform the services, procedures or other interventions which may have been requested for inclusion in the Scope of Practice, they may recommend to the Hospital CEO/Director of Nursing to:

- (a) initiate an Internal Review;
- (b) initiate an External Review;
- (c) grant Scope of Practice for a limited period of time followed by review;
- (d) apply conditions or limitations to Scope of Practice requested; and/or,
- (e) apply requirements for Relevant clinical services, procedures or other interventions to be performed under supervision or monitoring.

(a) If the Medical Practitioner's Credentials and assessed Competence and Performance do not meet the Threshold Credentials (if any) established for the requested Scope of Practice (if any), the MAC may recommend refusal of the application.

## **8.3 Consideration of applications for Initial Accreditation by the Hospital CEO/Director of Nursing**

8.3.1 The Hospital CEO/Director of Nursing will consider applications for Initial Accreditation as Medical Practitioners referred by the Medical Advisory Committee and will decide whether the applications should be rejected or approved and, if approved, whether any conditions should apply.

8.3.2 In considering applications, the Hospital CEO/Director of Nursing will give due consideration to any other information Relevant to the application as determined by the Hospital CEO/Director of Nursing, but the final decision is that of the Hospital CEO/Director of Nursing who will not be bound by the recommendation of the Medical Advisory Committee. In addition to considering the recommendations of the Medical Advisory Committee, including Organisational Capability and Organisational Need, the Hospital CEO/Director of Nursing may consider any matter assessed as Relevant to making the determination in the circumstances of a particular case.

- 8.3.3 The Hospital CEO/Director of Nursing may adjourn consideration of an application in order to obtain further information from the Medical Advisory Committee, the Medical Practitioner or any other person or organisation.
- 8.3.4 If the Hospital CEO/Director of Nursing requires further information from the Medical Practitioner before making a determination, they will forward a letter to the Medical Practitioner:
- (a) informing the Medical Practitioner that the Hospital CEO/Director of Nursing requires further information from the Medical Practitioner before deciding the application;
  - (b) identifying the information required. This may include, but is not limited to, information from third parties such as other hospitals relating to current or past Accreditation, Scope of Practice and other issues relating to or impacting upon the Accreditation with that other hospital; and
  - (c) requesting that the Medical Practitioner provide the information in writing or consent to contacting a third party for information or documents, together with any further information the Medical Practitioner considers Relevant within fourteen (14) days from the date of receipt of the letter.
- 8.3.5 In the event that the information or documents requested by the Hospital CEO/Director of Nursing is not supplied in the time set out in the letter, the Hospital CEO/Director of Nursing may, at their discretion, reject the application or proceed to consider the application without such additional information.
- 8.3.6 The Hospital CEO/Director of Nursing will forward a letter to the Medical Practitioner advising the Medical Practitioner whether the application has been approved or rejected. If the application has been approved, the letter will also contain details of the Scope of Practice granted.
- 8.3.7 There is no right of appeal from a decision to reject an initial application for Accreditation, or any terms or conditions that may be attached to approval of an application for initial Accreditation.

#### **8.4 Initial Accreditation tenure**

- 8.4.1 Initial Accreditation as a Medical Practitioner at the Relevant Hospital may, at the election of the Hospital CEO/Director of Nursing, be for a probationary period of one year.
- 8.4.2 Prior to the end of any probationary period established pursuant to By-law 8.4.1, a review of the Medical Practitioner's level of Competence, Current Fitness, Performance, compatibility with Organisational Capability and Organisational Need, and confidence in the Medical Practitioner will be undertaken by the Hospital CEO/Director of Nursing. The Hospital CEO/Director of Nursing may seek assistance with the review from the Relevant Medical Advisory Committee or Speciality Committee where established. The Hospital CEO/Director of Nursing may initiate the review at any time during the probationary period where concerns arise about Performance, Competence, Current Fitness of, or confidence in the Medical Practitioner, or there is evidence of Behavioural Sentinel Events exhibited by the Medical Practitioner.
- 8.4.3 In circumstances where in respect of a Medical Practitioner:
- (a) a review conducted by the Hospital CEO/Director of Nursing at the end of the probationary period; or

- (b) a review conducted by the Hospital CEO/Director of Nursing at any time during the probationary period; and
- (c) causes the Hospital CEO/Director of Nursing to consider:
  - (a) the Medical Practitioner's Scope of Practice should be amended; or
  - (b) the probationary period should be terminated; or
  - (c) the probationary period should be extended; or
  - (iv) the Medical Practitioner should not be offered Re-accreditation;
- (d) the Medical Practitioner will be:
  - (i) notified of the circumstances which have given rise to the Relevant concerns; and
  - (ii) be given an opportunity to be heard and present his/her case.

8.4.4 Should the Medical Practitioner have an acceptable probationary Accreditation review outcome, or in circumstances where Initial Accreditation is granted without a probationary period, the Hospital CEO/Director of Nursing, in consultation with the Medical Advisory Committee, may grant an Accreditation period of up to five (5) years (excluding Victoria which can be for a period of up to three (3) years per the Health Services (Health Services Establishments) Regulation 2024), on receipt of a signed declaration from the Medical Practitioner describing any specific changes, if any, to the initial information provided and ongoing compliance with all requirements as per the By-Laws.

8.4.5 Should the probationary Accreditation review outcome be unacceptable to the Hospital CEO/Director of Nursing, they may, in consultation with the MAC:

- (a) amend the Scope of Practice granted; or
- (b) decide that Accreditation will not be granted.

8.4.6 The Hospital CEO/Director of Nursing will make a final determination on Accreditation for all Medical Practitioners, including at the end of the probationary period. There will be no right of appeal at the end of the probationary period for a determination that Accreditation will not be granted following conclusion of the probationary period, or to any terms or conditions that may be attached to the grant of any Accreditation following the probationary period. All Medical Practitioners must agree with this as a condition of Initial Accreditation.

## 8.5 Re-Accreditation

8.5.1 The Cura Credentialling Delegate will, at least three months prior to the expiration of any term of Accreditation of each Medical Practitioner (other than a probationary period), provide to that Medical Practitioner an electronic link to the application form to be used in applying for Re-Accreditation.

8.5.2 Any Medical Practitioner wishing to be Re-Accredited must send the completed electronic application form to the Cura Credentialling Delegate at least two months prior to the expiration date of the Medical Practitioner's current term of Accreditation.

8.5.3 The Hospital CEO/Director of Nursing and Medical Advisory Committee will deal with applications for Re-Accreditation in the same manner in which they are required to deal with applications for Initial Accreditation as Medical Practitioners.

8.5.4 The rights of appeal conferred upon Medical Practitioners who apply for Re-Accreditation as Medical Practitioners are set out in these By-Laws.

## 8.6 Re-Accreditation tenure

Granting of Accreditation and Scope of Practice subsequent to any probationary period will be for a term of up to five (5) years (excluding Victoria which can be for a period of up to three (3) years per the Health Services (Health Services Establishments) Regulation 2024), as determined by the Hospital CEO/Director of Nursing.

## 8.7 Mutual Recognition of Accreditation at Additional Cura Facility

### 8.7.1 Purpose

This By-Law establishes a mutual recognition framework that allows the Facility CEO/Director of Nursing at a receiving Cura Facility to recognise, on a case-by-case basis, the credentialing undertaken at another Cura Hospital (the **originating Cura Facility**), to avoid unnecessary duplication of the full credentialing process while preserving the obligation of the receiving Cura Hospital to confirm that the Accredited Practitioner's Scope of Practice is appropriate for that Relevant Hospital (**Mutual Recognition**).

### 8.7.2 Eligibility

An Accredited Practitioner may seek Mutual Recognition at a receiving Cura Facility if the Practitioner:

- (a) holds current Accreditation at an originating Cura Facility at the time of the application;
- (b) holds a current Cura-approved Scope of Practice at the originating Cura Facility that is consistent with, or not materially broader than, the Scope of Practice sought at the receiving Cura Facility; and
- (c) holds current registration with the relevant national health practitioner registration authority (as monitored through Cura's automated AHPRA integration) and current Adequate Professional Indemnity Insurance.

### 8.7.3 Application process

Prior to submitting an application for Mutual Recognition of Accreditation under this By-Law, the Accredited Practitioner must notify the Hospital CEO/Director of Nursing of the receiving Cura Facility of their intention to seek Accreditation and identify all Cura Hospitals at which they currently hold Accreditation. The Hospital CEO/Director of Nursing will notify the Cura Credentialing Delegate to obtain all relevant credentialing documents and information from the originating Cura Hospital through Cura's e-credentialing system (**ECS**) to support the assessment process.

### 8.7.4 Assessment

- (a) Mutual Recognition is available on a case-by-case basis. The Hospital CEO/Director of Nursing of the receiving Cura Facility must, before granting Mutual Recognition of Accreditation under this By-Law, determine that:
  - (i) the requested Scope of Practice is consistent with, or narrower than, the Accredited Practitioner's existing Cura-approved Scope of Practice at the originating Cura Facility;

- (ii) the requested Scope of Practice is appropriate having regard to the Organisational Need and Organisational Capability of the receiving Cura Facility; and
  - (iii) the Accredited Practitioner has completed any site-specific orientation and meets any mandatory requirements applicable at the receiving Cura Facility.
- (b) The Hospital CEO/Director of Nursing may rely on credentialing documentation already verified at the originating Cura Facility through the ECS (but is not required to do so) and must satisfy themselves as to the currency and adequacy of that documentation.
- (c) Full Re-Accreditation will not be required where the existing Cura credentialing requirements have been satisfied, and no material change to the Scope of Practice is sought.
- (d) Where an Accredited Practitioner requests a change or expansion to their Scope of Practice, the request must be managed in accordance with the provisions of these By-Laws applicable to applications for Variation of Accreditation or Scope of Practice (clause 10) and, where applicable, to obtain written approval for New Clinical Services (clause 6.12).
- (e) Notwithstanding the Mutual Recognition approach under this By-Law, the Hospital CEO/Director of Nursing of the receiving Cura Facility retains discretion to require that some or all of the usual Accreditation requirements be completed where the Hospital CEO/Director of Nursing reasonably determines that there are:
- (i) material differences in the Scope of Practice requested at the receiving Cura Facility compared with the Practitioner's existing Cura-approved Scope of Practice;
  - (ii) material differences in the Organisational Need or Organisational Capability of the receiving Cura Hospital; or
  - (iii) identified governance risks that warrant further assessment.

#### 8.7.5 **Scope of Practice**

Accredited Practitioners must be aware that the Scope of Practice approved at the receiving Cura Facility may differ from the Scope of Practice approved at the originating Cura Hospital, having regard to the Organisational Need and Organisational Capability of the receiving Cura Facility. The Hospital CEO/Director of Nursing retains authority to request additional information or undertake further assessment where there are material differences in Scope of Practice, service capability, or identified governance risks.

#### 8.7.6 **Mutual Recognition of Accreditation period**

- (a) Where Mutual Recognition of Accreditation is granted under this By-Law, the period of Accreditation at the receiving Cura Facility will align with the Accredited Practitioner's existing Cura credentialing cycle and expiry date at the originating Cura Hospital, subject to any maximum Accreditation period prescribed by applicable law in the relevant jurisdiction, unless the Hospital CEO/Director of Nursing of the receiving Cura Facility determines otherwise in writing, with written reasons, having regard to local service requirements or governance considerations.

- (b) Where the Hospital CEO/Director of Nursing determines that a different Accreditation period applies, the Accredited Practitioner must be notified in writing of the period and the reason for the departure from the standard alignment.

#### **8.7.7 Relationship to Policy**

This By-Law is to be read together with the Credentialing and Scope of Practice of Health Professionals Policy. In the event of any inconsistency between this By-Law and the Credentialing and Scope of Practice of Health Professionals Policy on a matter governed by this By-Law, this By-Law prevails.

#### **8.7.8 Overriding Considerations**

Accreditation at multiple Cura Facilities remains subject to the access and resource provisions of these By-Laws at each Relevant Hospital, and Accreditation at one Cura Facility confers no entitlement to access facilities, equipment, or resources at any other Cura Facility.

#### **8.7.9 Appeal**

A decision made under this clause 8.7, including a decision to refuse to grant Mutual Recognition of Accreditation, to grant Mutual Recognition of Accreditation with a narrower Scope of Practice than sought, or to require that some or all of the usual Accreditation requirements be completed, constitutes a decision in relation to initial Accreditation at the receiving Cura Facility. Accordingly, there is no right of appeal under these By-Laws from any such decision.

### **8.8 Accreditation for Public Theatre Sessions at The Eye Hospital**

- 8.8.1 A Medical Practitioner accredited at Launceston General Hospital may, at the complete discretion of the Hospital CEO/Director of Nursing, receive Accreditation at The Eye Hospital in order to perform public theatre sessions as set out in this clause 8.8.
- 8.8.2 The Hospital CEO/Director of Nursing will request written confirmation of the applicant's accreditation at Launceston General Hospital and where requested by the Hospital CEO/Director of Nursing the applicant will consent to the Hospital CEO/Director of Nursing contacting Launceston General Hospital directly for Relevant documentation and information.
- 8.8.3 The Hospital CEO/Director of Nursing, upon receipt of the confirmation of the applicant's accreditation at Launceston General Hospital will decide whether it is appropriate to grant Accreditation with Scope of Practice limited to public theatre sessions at The Eye Hospital or whether application is required in accordance with clauses 8.1 to 8.4.
- 8.8.4 If Accreditation is granted pursuant to this clause 8.8, Scope of Practice must be limited to public theatre sessions at The Eye Hospital and any broader Scope of Practice must be applied for in accordance with clauses 8.1 to 8.4.
- 8.8.5 Accreditation granted pursuant to this clause 8.8 will continue only for so long as Accreditation is held at Launceston General Hospital and will immediately cease if Accreditation is no longer held at Launceston General Hospital.

## **8.8A. Streamlined Accreditation of Medical Practitioner Surgical Assistants**

### **8.8A.1 Purpose**

This clause 8.8A establishes a streamlined Accreditation pathway for Medical Practitioners who seek Accreditation at a Relevant Hospital solely to perform the role of surgical assistant (**Surgical Assistant**).

### **8.8A.2 Eligibility**

A Medical Practitioner may apply for Accreditation as a Surgical Assistant under this clause 8.8A if the Medical Practitioner:

- (a) seeks a Scope of Practice limited to providing surgical assisting services in an operating theatre environment under the supervision and direction of an Accredited Medical Practitioner (Surgeon) at the Relevant Hospital;
- (b) does not seek admitting rights or the right to independently treat Patients; and
- (c) holds current registration with the AHPRA and Adequate Professional Indemnity Insurance covering the Scope of Practice sought.

### **8.8A.3 Application Process**

8.8A.3.1 An application for Accreditation as a Surgical Assistant must be made via Cura's e-credentialling system on the prescribed form.

8.8A.3.2 The Hospital CEO/Director of Nursing may rely on credentialing documentation already in the ECS and may request such further information or documentation as the Hospital CEO/Director of Nursing considers appropriate.

8.8A.3.3 The Hospital CEO/Director of Nursing may, in their discretion, refer the application to the MAC for recommendation, or determine the application without referral to the MAC, having regard to the limited Scope of Practice sought.

### **8.8A.4 Decision**

8.8A.4.1 The Hospital CEO/Director of Nursing will determine whether to approve or reject an application made under this clause 8.8A, having regard to the applicant's Credentials, Competence, Current Fitness, the Organisational Capability and Organisational Need of the Relevant Hospital, and any other matter the Hospital CEO/Director of Nursing considers relevant.

8.8A.4.2 The Hospital CEO/Director of Nursing will notify the applicant in writing of the decision, including the Scope of Practice granted (if approved).

### **8.8A.5 Scope of Practice**

8.8A.5.1 The Scope of Practice granted to a Surgical Assistant under this clause 8.8A is limited to the provision of surgical assisting services at the Relevant Hospital, performed under the direct supervision of an Accredited Medical Practitioner (Surgeon) who holds current Accreditation and an appropriate Scope of Practice at the Relevant Hospital.

8.8A.5.2 If a Surgical Assistant seeks a Scope of Practice that extends beyond surgical assisting services, the Medical Practitioner must apply for Accreditation in accordance with clauses 8.1 to 8.4.

### **8.8A.6 Period of Accreditation**

8.8A.6.1 Accreditation granted under this clause 8.8A will be for a period determined by the Hospital CEO/Director of Nursing, which will not exceed five (5) years (excluding Victoria, which can

be for a period of up to three (3) years per the Health Services (Health Services Establishments) Regulation 2024).

#### **8.8A.7 Application of By-Laws to Surgical Assistants**

8A.7.1 Subject to this clause 8A, the provisions of Part A (Terms and Conditions of Accreditation), clauses 9 to 12, and Part E of these By-Laws apply to a Surgical Assistant as if the Surgical Assistant were a Medical Practitioner Accredited under clause 8.

#### **8.8A.8 Appeal**

8.8A.8.1 There is no right of appeal under these By-Laws from any decision made under this clause 8.8A, including a decision to reject an application for Accreditation, to grant Accreditation with a narrower Scope of Practice than sought, to impose conditions on Accreditation, to suspend or terminate Accreditation, or to require that the applicant apply for Accreditation under clauses 8.1 to 8.3.

#### **8.9 Nature of appointment of Visiting Medical Practitioners**

8.9.1 Medical Practitioners who have received Accreditation pursuant to the By-Laws are entitled to make a request for access to Hospitals for the treatment and care of their patients within the limits of the defined Scope of Practice attached to such Accreditation at the Relevant Hospital and to utilise Hospitals provided by the Relevant Hospital for that purpose, subject to the provisions of the By-Laws, policies, resource limitations, and in accordance with Organisational Need and Organisational Capability.

8.9.2 The decision to grant access to Hospitals for the treatment and care of a Medical Practitioner's Patients is on each occasion within the sole discretion of the Hospital CEO/Director of Nursing and the grant of Accreditation contains no conferral of, or general expectation relating to, a 'right of access' to the Relevant Hospital or its resources.

8.9.3 A Medical Practitioner's use of the Hospitals for the treatment and care of patients is limited to the Scope of Practice granted and subject to the conditions upon which the Scope of Practice is granted, resource limitations, and Organisational Need and Organisational Capability. Accredited Practitioners acknowledge that admission or treatment of a particular Patient is subject always to bed availability, the availability or adequacy of nursing or allied health staff or Hospitals given the treatment or clinical care proposed.

8.9.4 Accreditation does not of itself constitute an employment contract nor does it establish a contractual relationship between the Medical Practitioner and the Relevant Hospital or a Medical Practitioner and Cura.

8.9.5 Accreditation is personal and cannot be transferred to, or exercised by, any other person.

8.9.6 It is a condition of accepting Accreditation, and of ongoing Accreditation, that the Accredited Practitioner understands and agrees that these By-Laws are the full extent of processes and procedures available to the Accredited Practitioner with respect to all matters relating to and impacting upon Accreditation, and no additional procedural fairness or natural justice principles will be incorporated or implied, other than processes and procedures that have been explicitly set out in these By-Laws;

8.9.7 Accredited Practitioners acknowledge and agree as a condition of the granting of, and ongoing Accreditation, that the granting of Accreditation establishes only that the Accredited Practitioner is a person able to provide services at the Relevant Hospital, as well as the obligations and expectations with respect to the Accredited Practitioner while providing services for the period of Accreditation, the granting of Accreditation creates no rights or legitimate expectation with respect to access to the Relevant Hospital or its resources, and

while representatives of Cura and the Relevant Hospital will generally conduct themselves in accordance with these By-Laws they are not legally bound to do so and there are no legal consequences for not doing so.

## **9. Extraordinary Accreditation**

### **9.1 Temporary Accreditation**

- 9.1.1 The Hospital CEO/Director of Nursing may grant Medical Practitioners Temporary Accreditation and Scope of Practice on terms and conditions considered appropriate by the Hospital CEO/Director of Nursing. Temporary Accreditation will only be granted based on patient need, organisational capability and organisational Need. The Hospital CEO/Director of Nursing may consider Emergency Accreditation for short notice requests.
- 9.1.2 Applications for Temporary Accreditation as Medical Practitioners must be made via Cura's electronic credentialling system on the prescribed form as for initial applications. All questions on the prescribed form must be fully completed and required information and documents submitted before an application will be considered.
- 9.1.3 Temporary Accreditation may be terminated by the Hospital CEO/Director of Nursing for failure by the Medical Practitioner to comply with the requirements of the By-Laws or following provisions of Temporary Accreditation requirements.
- 9.1.4 Temporary Accreditation will automatically cease upon a determination by the Hospital CEO/Director of Nursing of the Medical Practitioner's application for Accreditation or at such other time following such determination as the Hospital CEO/Director of Nursing decides. The period of Temporary Accreditation will be determined by the Hospital CEO/Director of Nursing, which will be for a period of no longer than three (3) months. Any extension is at the discretion of the CEO/Director of Nursing and will be no longer than an additional three (3) months and must be approved in writing by the CEO/Director of Nursing. Any further extensions of temporary accreditation beyond the additional three (3) months must be approved in writing by the National Hospitals Operations Manager.
- 9.1.5 There can be no expectation that a grant of Temporary Accreditation will mean that there will be a subsequent granting of Accreditation.
- 9.1.6 The MAC will be informed of all Temporary Accreditation granted.
- 9.1.7 There will be no right of appeal from decisions relating to the granting of Temporary Accreditation or termination of Temporary Accreditation.

### **9.2 Emergency Accreditation**

- 9.2.1 In the case of an emergency, any Medical Practitioner, to the extent permitted by the terms of the Medical Practitioner's registration, may request Emergency Accreditation and granting of Scope of Practice in order to continue the provision of treatment and care to patients. Emergency Accreditation may be considered by the Hospital CEO/Director of Nursing for short notice requests, to ensure continuity and safety of care for patients and/or to meet Organisational Need.
- 9.2.2 As a minimum, the following is required:
- (a) verification of identity through inspection of Relevant documents (e.g. driver's licence with photograph);

- (b) immediate contact with a member of senior management of an organisation nominated by the Medical Practitioner as their most recent place of Accreditation to verify employment or appointment history;
- (c) verification of professional registration and insurance as soon as practicable;
- (d) confirmation of at least one professional referee of the Medical Practitioner's Competence and good standing; and
- (e) verification will be undertaken by the Hospital CEO/Director of Nursing and will be fully documented.

9.2.3 Emergency Accreditation will be followed as soon as practicable with Temporary Accreditation or Initial Accreditation application processes if required.

9.2.4 Emergency Accreditation will be approved for a limited period as identified by the Hospital CEO/Director of Nursing, for the safety of patients involved, and will automatically terminate at the expiry of that period or as otherwise determined by the Hospital CEO/Director of Nursing.

9.2.5 The MAC will be informed of all Emergency Accreditations.

9.2.6 There will be no right of appeal from decisions on granting, or termination, of Emergency Accreditation.

### **9.3 Locum Tenens**

9.3.1 Locums must be approved by the Hospital CEO/Director of Nursing before they are permitted to arrange the admission of and/or to treat Patients on behalf of Visiting Medical Practitioners.

9.3.2 Temporary Accreditation requirements must be met before approval of locums is granted.

9.3.3 There will be no right of appeal from decisions in relation to locum appointments.

## **10. Variation of Accreditation or Scope of Practice**

### **10.1 Practitioner may request amendment of Accreditation or Scope of Practice**

10.1.1 An Accredited Medical Practitioner may apply for an amendment or variation of their existing Scope of Practice or any term or condition of their Accreditation, other than in relation to the general terms and conditions applying to all Accredited Practitioners as provided in these By-Laws.

10.1.2 The process for amendment or variation is the same for an application for Re-Accreditation, except the Medical Practitioner will be required to complete a Request for Amendment of Accreditation or Scope of Practice Form and provide Relevant documentation and references in support of the amendment or variation.

10.1.3 The process to adopt in consideration of the application for amendment or variation will be as set out in clauses 8.1 to 8.3.

10.1.4 The rights of appeal conferred upon Medical Practitioners who apply for amendment or variation are set out in these By-Laws, except an appeal is not available for an application made during a probationary period, or in relation to Temporary Accreditation, Emergency Accreditation, or a Locum Tenens.

## 11. Review of Accreditation or Scope of Practice

### 11.1 Authorised Person may initiate review of Accreditation or scope of practice

11.1.1 The Hospital CEO/Director of Nursing may at any time initiate a review of a Medical Practitioner's Accreditation or Scope of Practice where concerns or an allegation are raised about any of the following:

- (a) Patient health or safety could potentially be compromised;
- (b) the rights or interests of a Patient, staff or someone engaged in or at the Relevant Hospital has been adversely affected or could be infringed upon;
- (c) non-compliance with the Behavioural Standards;
- (d) the Medical Practitioner's level of Competence;
- (e) the Medical Practitioner's Current Fitness;
- (f) the Medical Practitioner's Performance;
- (g) compatibility with Organisational Capability and Organisational Need;
- (h) the current Scope of Practice granted does not support the care or treatment sought to be undertaken by the Medical Practitioner;
- (i) confidence in the Medical Practitioner;
- (j) compliance with these By-Laws, including terms and conditions;
- (k) a possible ground for suspension or termination of Accreditation may have occurred;
- (l) the efficient operation of the Relevant Hospital could be threatened or disrupted, the potential loss of the Relevant Hospital's licence or accreditation, or the potential to bring the Relevant Hospital into disrepute;
- (m) a breach of a legislative or legal obligation of Cura or the Relevant Hospital or imposed upon the Accredited Practitioner may have occurred;
- (n) the Accredited Practitioner has breached the AI Use Policy, including by using an unapproved AI System, uploading Patient Personal Information or Cura Confidential Information to an unapproved AI System, or failing to maintain appropriate clinical oversight of an AI System output used in connection with Patient care; or
- (o) as elsewhere defined in these By-Laws.

11.1.2 The Hospital CEO/Director of Nursing, in consultation with the Chief Executive Officer and/or the National Hospitals Operations Manager will determine whether the process to be followed is an;

- (a) Internal Review; or
- (b) External Review.

11.1.3 Prior to determining whether an Internal Review or External Review will be conducted, the Hospital CEO/Director of Nursing may in his or her absolute discretion meet with the Medical Practitioner, along with any other persons the Hospital CEO/Director of Nursing considers appropriate, advise of the concern or allegation raised, and invite a preliminary response from the Medical Practitioner (in writing or orally as determined by the Hospital CEO/Director of Nursing) before the Hospital CEO/Director of Nursing, in consultation with

the Chief Executive Officer and/or National Hospitals Operations Manager makes a determination whether a review will proceed, and if so, the type of review.

- 11.1.4 The review may have wider terms of reference than a review of the Medical Practitioner's Accreditation or Scope of Practice.
- 11.1.5 The Hospital CEO/Director of Nursing must make a determination whether to impose an interim suspension or conditions upon the Accreditation of the Medical Practitioner pending the outcome of the review and, if imposed, there is no right of appeal from this interim decision pursuant to the By-Laws.
- 11.1.6 In addition or as an alternative to conducting an internal or external review, the Hospital CEO/Director of Nursing, in consultation with the Chief Executive Officer and/or the National Hospitals Operations Manager will notify the Medical Practitioner's registration board and/or other professional body responsible for the Medical Practitioner of details of the concerns raised if required by legislation, otherwise the Hospital CEO/Director of Nursing may notify if the Hospital CEO/Director of Nursing considers it is in the interests of Patient care or safety to do so, it is in the interests of protection of the Public (including patients at other Hospitals) to do so, or it is considered that the registration board or professional body is more appropriate to investigate and take necessary action. Following the outcome of any action taken by the registration board and/or other professional body the Hospital CEO/Director of Nursing may elect to take action, or further action, under these By-Laws.

## **11.2 Internal Review of Accreditation and Scope of Practice**

- 11.2.1 The Hospital CEO/Director of Nursing, in consultation with the Chief Executive Officer and/or the National Hospitals Operations Manager will establish the terms of reference of the Internal Review and may seek assistance of the Medical Advisory Committee or co-opted Medical Practitioners or personnel from within Cura who bring specific expertise to the Internal Review as determined by the Hospital CEO/Director of Nursing.
- 11.2.2 The terms of reference, process, and reviewers will be as determined by the Hospital CEO/Director of Nursing in consultation with the Chief Executive Officer and/or the National Hospitals Operations Manager. The process will ordinarily include the opportunity for submissions from the Medical Practitioner, which may be written and/or oral.
- 11.2.3 The Hospital CEO/Director of Nursing will notify the Medical Practitioner in writing of the review, the terms of reference, process and reviewers.
- 11.2.4 A detailed report on the findings of the review in accordance with the terms of reference will be provided by the reviewers to the Hospital CEO/Director of Nursing.
- 11.2.5 Following consideration of the report, the Hospital CEO/Director of Nursing, in consultation with the Chief Executive Officer and/or the National Hospitals Operations Manager is required to make a determination of whether or not to continue (including with conditions), amend, suspend or terminate a Medical Practitioner's Accreditation in accordance with these By-Laws.
- 11.2.6 The Hospital CEO/Director of Nursing must notify the Medical Practitioner in writing of the determination made in relation to the Accreditation, the reasons for it, and advise of the right of appeal, the appeal process and the timeframe for an appeal.
- 11.2.7 The Medical Practitioner will have the rights of appeal established by these By-Laws in relation to the final determination made by the Hospital CEO/Director of Nursing if a decision is made to amend, suspend, terminate or impose conditions on the Medical Practitioner's Accreditation.

11.2.8 In addition or as an alternative to taking action in relation to the Accreditation follow receipt of the report, the Hospital CEO/Director of Nursing will notify the Medical Practitioner's registration board and/or other professional body responsible for the Medical Practitioner of details of the concerns raised and outcome of the review if required by legislation, otherwise the Hospital CEO/Director of Nursing may notify if the Hospital CEO/Director of Nursing considers it is in the interests of Patient care or safety to do so, it is in the interests of protection of the Public (including patients at other Hospitals) to do so, it is considered appropriate that the registration board or professional body consider the matter, or it should be done to protect the interests of the Relevant Hospital or Cura.

### **11.3 External Review of Accreditation and Scope of Practice**

11.3.1 The Hospital CEO/Director of Nursing, in consultation with the Chief Executive Officer and/or the National Hospitals Operations Manager will make a determination about whether an External Review will be undertaken.

11.3.2 An External Review will be undertaken by a person(s) external to Cura, the Relevant Hospital and of the Accredited Medical Practitioner in question and such person(s) will be nominated by the Hospital CEO/Director of Nursing at his/her discretion.

11.3.3 The terms of reference, process, and reviewers will be as determined by the Hospital CEO/Director of Nursing, in consultation with the Chief Executive Officer and /or the National Hospitals Operations Manager. The process will ordinarily include the opportunity for submissions from the Medical Practitioner, which may be written and/or oral.

11.3.4 The Hospital CEO/Director of Nursing will notify the Medical Practitioner in writing of the review, the terms of reference, process and reviewers.

11.3.5 The external reviewer is required to provide a detailed report on the findings of the review in accordance with the terms of reference to the Hospital CEO/Director of Nursing.

11.3.6 The Hospital CEO/Director of Nursing, in consultation with the Chief Executive Officer and/or the National Hospitals Operations Manager will review the report from the External Review and make a determination of whether to continue (including with conditions), amend, suspend or terminate the Medical Practitioner's Accreditation or Scope of Practice in accordance with these By-Laws.

11.3.7 The Hospital CEO/Director of Nursing must notify the Medical Practitioner in writing of the determination made in relation to the Accreditation, the reasons for it, and advise of the right of appeal, the appeal process, and the timeframe for an appeal.

11.3.8 The Medical Practitioner will have the rights of appeal established by these By-Laws in relation to the final determination made by the Hospital CEO/Director of Nursing if a decision is made to amend, suspend, terminate, or impose conditions on the Medical Practitioner's Accreditation.

11.3.9 In addition or as an alternative to taking action in relation to the Accreditation follow receipt of the report, the Hospital CEO/Director of Nursing will notify the Medical Practitioner's registration board and/or other professional body responsible for the Medical Practitioner of details of the concerns raised and outcome of the review if required by legislation, otherwise the Hospital CEO/Director of Nursing may notify if the Hospital CEO/Director of Nursing considers it is in the interests of Patient care or safety to do so, it is in the interests of protection of the Public (including patients at other Hospitals) to do so, it is considered appropriate that the registration board or professional body consider the matter, or it should be done to protect the interests of the Relevant Hospital or Cura.

## 12 Suspension, termination, imposition of conditions, resignation and expiry of Accreditation

### 12.1 Suspension of Accreditation

12.1.1 The Hospital CEO/Director of Nursing may, following consultation with the Chief Executive Officer and/or the National Hospitals Operations Manager where practicable, immediately suspend a Medical Practitioner's Accreditation should the Hospital CEO/Director of Nursing believe, or have a sufficient concern:

- (a) it is in the interests of Patient care or safety. This can be based upon an investigation by an external agency including a registration board, disciplinary body, Coroner or health complaints body, and may be related to a patient or patients at another facility not operated by Cura;
- (b) the continuance of the current Scope of Practice raises a significant concern about the safety and quality of health care to be provided by the Medical Practitioner;
- (c) it is in the interests of staff welfare or safety;
- (d) serious and unresolved allegations have been made in relation to the Medical Practitioner. This may be related to a patient or patients of another facility not operated by Cura, including if these are the subject of review by an external agency including a registration board, disciplinary body, Coroner or a health complaints body;
- (e) the Medical Practitioner fails to observe the terms and conditions of his/her Accreditation;
- (f) the behaviour or conduct is in breach of a direction or an undertaking, or the Relevant Hospital or Cura By-Laws, policies and procedures;
- (g) the behaviour or conduct is such that it is unduly hindering the efficient operation of the Relevant Hospital at any time, is bringing the Relevant Hospital or Cura into disrepute, does not comply with the Behaviour Standards, is consider disruptive or a Behavioural Sentinel Event or is inconsistent with the values of Cura;
- (h) the Medical Practitioner has been suspended by their registration board;
- (i) there is a finding of professional misconduct, unprofessional conduct, unsatisfactory professional conduct or some other adverse professional finding (however described) by a registration board or other Relevant disciplinary body or professional standards organisation for the Medical Practitioner;
- (j) the Medical Practitioner's professional registration is amended, or conditions imposed, or undertakings agreed, irrespective of whether this relates to a current or former Patient of the Relevant Hospital;
- (k) the Medical Practitioner has made a false declaration or provided false or inaccurate information to the Relevant Hospital, either through omission of important information or inclusion of false or inaccurate information;
- (l) the Medical Practitioner fails to make the required notifications required to be given pursuant to these By-Laws or based upon the information contained in a notification suspension is considered appropriate;
- (m) the Accreditation, clinical privileges or Scope of Practice of the Medical Practitioner has been suspended, terminated, restricted or made conditional by another health care organisation;

- (n) the Medical Practitioner is the subject of a criminal investigation about a serious matter (for example a drug related matter, or an allegation of a crime against a person such as a sex or violence offence) which, if established, could affect his or her ability to exercise his or her Scope of Practice safely and competently and with the confidence of the Relevant Hospital and the broader community;
- (o) the Medical Practitioner has been convicted of a crime which could affect his or her ability to exercise his or her Scope of Practice safely and competently and with the confidence of the Relevant Hospital and the broader community;
- (p) based upon a finalised Internal Review or External Review pursuant to these By-Laws any of the above criteria for suspension are considered to apply;
- (q) an Internal Review or External Review has been initiated pursuant to these By-Laws and the Hospital CEO/Director of Nursing considers that an interim suspension is appropriate pending the outcome of the review;
- (r) there are other unresolved issues or other concerns in respect of the Medical Practitioner that is considered to be a ground for suspension; and
- (s) the Accredited Practitioner has used, or has caused or permitted to be used, an AI System in a Clinical Context in a manner that poses an immediate or serious risk to Patient safety, including through use of an unapproved AI system or use of an approved AI System outside its approved use case, in circumstances where the Hospital CEO/Director of Nursing, in consultation with the Chief Executive Officer, considers it is in the interests of Patient care or safety to suspend Accreditation.

12.1.2 The Hospital CEO/Director of Nursing will notify the Medical Practitioner of:

- (a) the fact of the suspension;
- (b) the period of suspension;
- (c) the reasons for the suspension;
- (d) if the Hospital CEO/Director of Nursing considers it applicable and appropriate in the circumstances, invite a written response from the Medical Practitioner, including a response as to why the Medical Practitioner may consider the suspension should be lifted;
- (e) if Hospital CEO/Director of Nursing considers it applicable and appropriate in the circumstances, any actions that must be performed for the suspension to be lifted and the period within which those actions must be completed; and
- (f) the right of appeal, the appeal process and the time frame for an appeal.

12.1.3 As an alternative to an immediate suspension, the Hospital CEO/Director of Nursing may elect to deliver a show cause notice to the Medical Practitioner advising of:

- (a) the facts and circumstances forming the basis for possible suspension;
- (b) the grounds under the By-Laws upon which suspension may occur;
- (c) invite a written response from the Medical Practitioner, including a response why the Medical Practitioner may consider suspension is not appropriate;

- (d) if applicable and appropriate in the circumstances, any actions that must be performed for the suspension not to occur and the period within which those actions must be completed; and
- (e) a timeframe in which a response is required from the Medical Practitioner to the show cause notice;

12.1.4 Following receipt of the response the Hospital CEO/Director of Nursing will determine whether the Accreditation will be suspended. If suspension is to occur, notification will be sent in accordance with clause 12. Otherwise, the Medical Practitioner will be advised that suspension will not occur, however this will not prevent the Hospital CEO/Director of Nursing from taking other action at this time, including imposition of conditions, and will not prevent the Hospital CEO/Director of Nursing from relying upon these matters as a ground for suspension or termination in the future.

12.1.5 The suspension is ended either by terminating the Accreditation or lifting the suspension. This will occur by written notification by the Hospital CEO/Director of Nursing.

12.1.6 The affected Medical Practitioner will have the rights of appeal set out in these By-Laws.

12.1.7 The Hospital CEO/Director of Nursing will notify the Chief Executive Officer and/or the Hospitals Operations Manager of any suspension of Accreditation.

12.1.8 If there is held, in good faith, a belief that the matters forming the grounds for suspension give rise to a significant concern about the safety and quality of health care provided by the Medical Practitioner including but not limited to patients outside of Cura, it is in the interests of Patient care or safety to do so, it is in the interests of protection of the Public (including patients at other Hospitals) to do so, it is required by legislation, or for other reasonable grounds, the Hospital CEO/Director of Nursing will notify the Medical Practitioner's registration board and/or other Relevant regulatory agency of the suspension and the reasons for it.

12.1.9 Accredited Practitioners accept and agree that, as part of the acceptance of Accreditation, a suspension of Accreditation carried out in accordance with these By-Laws is a safety and protective process rather than a punitive process, and as such it does not result in an entitlement to any compensation, including for economic loss or reputational damage.

## **12.2 Termination of Accreditation**

12.2.1 Accreditation shall be immediately terminated by the Hospital CEO/Director of Nursing if the following has occurred, or if it appears based upon the information available to the Hospital CEO/Director of Nursing the following has occurred:

- (a) the Medical Practitioner ceases to be registered with their Relevant registration board;
- (b) the Medical Practitioner ceases to maintain Adequate Professional Indemnity Insurance covering the Scope of Practice;
- (c) a term or condition that attaches to an approval of Accreditation is breached, not satisfied, or according to that term or condition results in the Accreditation concluding; or a contract of employment or to provide services is terminated or ends, and is not renewed.

12.2.2 Accreditation may be terminated by the Hospital CEO/Director of Nursing, following consultation with the Chief Executive Officer and/or the National Hospitals Operations

Manager, where practicable, if the following has occurred, or if it appears based upon the information available to the Hospital CEO/Director of Nursing the following has occurred:

- (a) it is considered suspension is an insufficient response in the circumstances;
- (b) based upon a finalised Internal Review or External Review pursuant to these By-Laws and termination of Accreditation is considered appropriate in the circumstances or in circumstances where the Hospital CEO/Director of Nursing does not have confidence in the continued appointment of the Medical Practitioner;
- (c) the Medical Practitioner is not regarded by the Hospital CEO/Director of Nursing as having the appropriate Current Fitness to retain Accreditation or the Scope of Practice, or the Hospital CEO/Director of Nursing does not have confidence in the continued appointment of the Medical Practitioner;
- (d) conditions have been imposed by the Medical Practitioner's registration board on clinical practice that restricts practice and the Relevant Hospital elects not to accommodate the conditions imposed;
- (e) the Medical Practitioner has not exercised Accreditation or utilised the Hospitals at the Relevant Hospital for a continuous period of 12 months, or at a level or frequency as otherwise specified to the Medical Practitioner by the Hospital CEO/Director of Nursing;
- (f) the Scope of Practice is no longer supported by Organisational Capability or Organisational Need;
- (g) the Medical Practitioner becomes permanently incapable of performing his/her duties which will for the purposes of these By-Laws be a continuous period of six months' incapacity; or
- (h) there are other unresolved issues or other concerns in respect of the Medical Practitioner that is considered to be a ground for termination.

12.2.3 The Accreditation of a Medical Practitioner may be terminated as otherwise provided in these By-Laws.

12.2.4 The Hospital CEO/Director of Nursing will notify the Medical Practitioner of:

- (a) the fact of the termination;
- (b) the reasons for the termination;
- (c) if the Hospital CEO/Director of Nursing considers it applicable and appropriate in the circumstances, invite a written response from the Medical Practitioner why they may consider a termination should not have occurred; and,
- (d) if a right of appeal is available in the circumstances, the right of appeal, the appeal process and the time frame for an appeal.

12.2.5 As an alternative to an immediate termination, the Hospital CEO/Director of Nursing may elect to deliver a show cause notice to the Medical Practitioner advising of:

- (a) the facts and circumstances forming the basis for possible termination;
- (b) the grounds under these By-Laws upon which termination may occur;
- (c) invite a written response from the Medical Practitioner, including a response why the Medical Practitioner may consider termination is not appropriate;

- (d) if applicable and appropriate in the circumstances, any actions that must be performed for the termination not to occur and the period within which those actions must be completed; and
  - (e) a timeframe in which a response is required from the Medical Practitioner to the show cause notice.
- 12.2.6 Following receipt of the response the Hospital CEO/Director of Nursing will determine whether the Accreditation will be terminated. If termination is to occur notification will be sent in accordance with these By-Laws. Otherwise, the Medical Practitioner will be advised that termination will not occur, however this will not prevent the Hospital CEO/Director of Nursing from taking other action at this time, including imposition of conditions, and will not prevent the Hospital CEO/Director of Nursing from relying upon these matters as a ground for suspension or termination in the future.
- 12.2.7 All terminations must be notified to the Chief Executive Officer and the National Hospitals Operations Manager.
- 12.2.8 For a termination of Accreditation pursuant to clause 12.2.1 there will be no right of appeal.
- 12.2.9 For a termination of Accreditation pursuant to clause 12.2.2 the Medical Practitioner will have the rights of appeal established by these By-Laws.
- 12.2.10 Unless it is determined not appropriate in the particular circumstances, the fact and details of the termination will be notified by the Hospital CEO/Director of Nursing to the Medical Practitioner's registration board and/or such other regulatory agency.
- 12.2.11 Accredited Practitioners accept and agree, as part of the acceptance of Accreditation, that a termination of Accreditation carried out in accordance with these By-Laws is a safety and protective process rather than a punitive process, and as such it does not result in an entitlement to any compensation, including for economic loss or reputational damage.
- 12.2.12 As a separate right and despite anything set out above in By-law 12.2, the CEO may terminate the Accreditation of an Accredited Practitioner without being required to provide reasons, by ordinarily providing no less than three (3) months written notice, or such other shorter or longer period as the CEO considers reasonable in the circumstances. There will be no right of appeal pursuant to these By-Laws from such a decision of the CEO.

### **12.3 Imposition of conditions**

- 12.3.1 At the conclusion of or pending finalisation of a review or in lieu of a suspension or in lieu of a termination, the Hospital CEO/Director of Nursing, following consultation with the Chief Executive Officer and/or the National Hospitals Operations Manager where practicable, may elect to impose conditions on the Accreditation or Scope of Practice.
- 12.3.2 The Hospital CEO/Director of Nursing must notify the Medical Practitioner in writing of the imposition of conditions, the reasons for it, the consequences if the conditions are breached, and advise of the right of appeal, the appeal process and the timeframe for an appeal.
- 12.3.3 If the Hospital CEO/Director of Nursing considers it applicable and appropriate in the circumstances, they may also invite a written response from the Medical Practitioner as to why the Medical Practitioner may consider the conditions should not be imposed.
- 12.3.4 If the conditions are breached, then suspension or termination of Accreditation may occur, as determined by the Hospital CEO/Director of Nursing.

- 12.3.5 The affected Medical Practitioner will have the rights of appeal established by these By-Laws.
- 12.3.6 If there is held, in good faith, a belief that the continuation of the unconditional right to practise in any other organisation would raise a significant concern about the safety and quality of health care for patients and the public, the Hospital CEO/Director of Nursing will notify the Medical Practitioner's registration board and/or other Relevant regulatory agency of the imposition of the conditions and the reasons the conditions were imposed.
- 12.3.9 Accredited Practitioners accept and agree, as part of the acceptance of Accreditation, that an imposition of conditions carried out in accordance with these By-Laws is a safety and protective process rather than a punitive process, and as such it does not result in an entitlement to any compensation, including for economic loss or reputational damage.

## **12.4 Notification to other Cura Hospitals**

- 12.4.1 The decision to suspend Accreditation and any other Relevant information will be notified by the Chief Executive Officer or the National Hospitals Operations Manager to the other Cura Hospitals where the Medical Practitioner is Accredited, as well as notification subsequently whether an appeal has been lodged. The Hospital CEO/Director of Nursing of that other Cura facility may, based upon this information and in consultation with the Chief Executive Officer or the National Hospitals Operations Manager elect to immediately suspend Accreditation or may elect to ask the Medical Practitioner to show cause why a suspension or other action should not occur at their facility.
- 12.4.2 The decision to terminate Accreditation and any other Relevant information will be notified by the Chief Executive Officer or the National Hospitals Operations Manager to the other Cura Hospitals where the Medical Practitioner is Accredited, as well as notification whether an appeal has been lodged (if an appeal is available in the circumstances). Unless the Chief Executive Officer or the National Hospitals Operations Manager decides otherwise in the circumstances of a particular case, the termination of Accreditation at one Cura facility will result in automatic termination of Accreditation at all other Cura Hospitals where the Medical Practitioner holds Accreditation. If an automatic termination of Accreditation has not occurred as determined by the Chief Executive Officer, or the National Hospitals Operations Manager the Hospital CEO/Director of Nursing of that other Cura facility may elect, based upon this information and in consultation with the Chief Executive Officer or the National Hospitals Operations Manager, to ask the Medical Practitioner to show cause why a termination or other action should not occur at their facility.
- 12.4.3 The decision to impose conditions and any other Relevant information will be notified by the Chief Executive Officer or the National Hospitals Operations Manager to the other Cura Hospitals where the Medical Practitioner is Accredited, as well as notification subsequently whether an appeal has been lodged. The Hospital CEO/Director of Nursing of the other Cura facility may, based upon this information and in consultation with the Chief Executive Officer or the National Hospitals Operations Manager elect to immediately impose the same conditions or may elect to ask the Medical Practitioner to show cause why the imposition of conditions or other action should not occur at their facility.

## **12.5 Resignation and expiry of Accreditation**

- 12.5.1 A Medical Practitioner may resign his/her Accreditation by giving one month's notice of the intention to do so to the Hospital CEO/Director of Nursing, unless a shorter notice period is otherwise agreed by the Hospital CEO/Director of Nursing.

- 12.5.2 A Medical Practitioner who intends ceasing treating Patients either indefinitely or for an extended period must notify his/her intention to the Hospital CEO/Director of Nursing, and Accreditation will be taken to be withdrawn one month from the date of notification unless the Hospital CEO/Director of Nursing decides a shorter notice period is appropriate in the circumstances.
- 12.5.3 If an application for Re-Accreditation is not received within the timeframe provided for in these By-Laws, unless determined otherwise by the Hospital CEO/Director of Nursing, the Accreditation will expire at the conclusion of its term. If the Medical Practitioner wishes to admit or treat Patients at the Relevant Hospital after the expiration of Accreditation, an application for Accreditation must be made as an application for Initial Accreditation.
- 12.5.4 If the Medical Practitioner's Scope of Practice is no longer supported by Organisational Capability or Organisational Need, if the Medical Practitioner will no longer be able to meet the terms and conditions of Accreditation, or where admission of Patients or utilisation of services at the Relevant Hospital is regarded by the Hospital CEO/Director of Nursing to be insufficient, the Hospital CEO/Director of Nursing will raise these matters in writing with the Accredited Practitioner and invite a meeting to discuss, following which the Hospital CEO/Director of Nursing and Accredited Practitioner may agree that Accreditation will expire and they will agree on the date for expiration of Accreditation. Following the date of expiration, if the Medical Practitioner wishes to admit or treat Patients at the Relevant Hospital, an application for Accreditation must be made as an application for Initial Accreditation.
- 12.5.5 The provisions in relation to resignation and expiration of Accreditation in no way limit the ability of the Hospital CEO/Director of Nursing to take action pursuant to other provisions of these By-Laws, including by way of suspension or termination of Accreditation.

## **13 Appeal rights and procedure**

### **13.1 Rights of appeal against decisions affecting Accreditation**

- 13.1.1 There will be no right of appeal against a decision to not approve initial Accreditation, Temporary Accreditation, Emergency Accreditation or locum Accreditation, continued Accreditation at the end of a probationary period or with respect to the period of Temporary Accreditation, Emergency Accreditation, or locum Accreditation.
- 13.1.2 Subject to clause 13.1.1, a Medical Practitioner will have the right of appeal as set out in these By-Laws.

### **13.2 Appeal process**

- 13.2.1 A Medical Practitioner will have 14 days from the date of notification of a decision to which there is a right of appeal in these By-Laws to lodge an appeal against the decision.
- 13.2.2 An appeal must be in writing to the Hospital CEO/Director of Nursing and received by the Hospital CEO/Director of Nursing within the 14-day appeal period or else the right to appeal is lost.
- 13.2.3 Unless decided otherwise by the Chief Executive Officer and/or the National Hospitals Operations Manager in the circumstances of the particular case, which will only be in exceptional circumstances, lodgement of an appeal does not result in a stay of the decision under appeal and the decision will stand and be actioned accordingly.

- 13.2.4 Upon receipt of an appeal notice the Hospital CEO/Director of Nursing will immediately forward the appeal request to the Chief Executive Officer and/or the National Hospitals Operations Manager.
- 13.2.5 The Chief Executive Officer and/or the National Hospitals Operations Manager will nominate an Appeal Committee to hear the appeal, establish terms of reference, and submit all Relevant material to the chairperson of the Appeal Committee.
- 13.2.6 The Appeal Committee will comprise at least three (3) persons and will include:
- (a) a nominee of the Chief Executive Officer and/or the National Hospitals Operations Manager who may be an Accredited Practitioner, who must be independent of the decision under appeal regarding the Medical Practitioner, and who will be the chairperson of the Appeal Committee;
  - (b) a nominee of the Hospital CEO/Director of Nursing of the Relevant Hospital, who may be an Accredited Practitioner, and who must be independent of the decision under appeal regarding the Medical Practitioner;
  - (c) any other member or members who bring specific expertise to the decision under appeal, as determined by the Chief Executive Officer and/or the National Hospitals Operations Manager who must be independent of the decision under appeal regarding the Medical Practitioner, and who may be an Accredited Practitioner. The Chief Executive Officer and/or the National Hospitals Operations Manager in their complete discretion may invite the appellant to make suggestions or comments on the proposed additional members of the Appeal Committee (other than the nominees in (i) and (ii) above) but is not bound to follow the suggestions or comments.
- 13.2.7 Before accepting the appointment, the nominees will confirm that they do not have a known conflict of interest with the appellant and will sign a confidentiality agreement. Once all members of the Appeal Committee have accepted the appointment, the Chief Executive Officer or the National Hospitals Operations Manager will notify the appellant of the members of the Appeal Committee.
- 13.2.8 Unless a shorter timeframe is agreed by the appellant and the Appeal Committee, the appellant will be provided with at least 14 days' notice of the date for determination of the appeal by the Appeal Committee. The notice from the Appeal Committee will ordinarily set out the date for determination of the appeal, the members of the Appeal Committee, the process that will be adopted, and will invite the appellant to make a submission about the decision under appeal. Subject to an agreement to confidentiality from the appellant, the chairperson may provide the appellant with copies of material to be relied upon by the Appeal Committee.
- 13.2.9 The appellant will be given the opportunity to make a submission to the Appeal Committee. The Appeal Committee will determine whether the submission by the appellant may be in writing or in person or both.
- 13.2.10 If the appellant elects to provide written submissions to the Appeal Committee, following such a request from the Appeal Committee for a written submission, unless a longer time frame is agreed between the appellant and Appeal Committee the written submission will be provided within 7 days of the request.
- 13.2.11 The Hospital CEO/Director of Nursing of the Relevant Hospital (or nominee) may present to the Appeals Committee in order to support the decision under appeal.

- 13.2.12 If the appellant attends before the Appeal Committee to answer questions and to make submissions, the appellant is not entitled to have formal legal representation at the meeting of the Appeal Committee. The appellant is entitled to be accompanied by a support person, who may be a lawyer, but that support person is not entitled to address the Appeal Committee.
- 13.2.13 The appellant must not be present during Appeal Committee deliberations except when invited to be heard in respect of his/her appeal.
- 13.2.14 The chairperson of the Appeal Committee will determine any question of procedure for the Appeal Committee, with questions of procedure entirely within the discretion of the chairperson of the Appeal Committee.
- 13.2.15 The Appeal Committee will make a written recommendation regarding the appeal to the Chief Executive Officer, and/or the National Hospitals Operations Manager, including provision of reasons for the recommendation. The recommendation may be made by a majority of the members of the Appeal Committee and if an even number of Appeal Committee members, then the chairperson has the deciding vote. A copy of the recommendation will be provided to the appellant.
- 13.2.16 The Chief Executive Officer or the National Hospitals Operations Manager will consider the recommendation of the Appeal Committee and make a decision about the appeal.
- 13.2.17 The decision of the Chief Executive Officer or the National Hospitals Operations Manager will be notified in writing to the appellant.
- 13.2.18 The decision of the Chief Executive Officer or the National Hospitals Operations Manager is final and binding, and there is no further appeal allowed under these By-Laws from this decision.
- 13.2.19 The decision of the Chief Executive Officer or the National Hospitals Operations Manager in relation to the appeal will be notified to other Cura Hospitals where the Medical Practitioner holds Accreditation.
- 13.2.20 If a notification has already been given to an external agency, such as a registration Board, then the Chief Executive Officer or the National Hospitals Operations Manager will notify that external agency of the appeal decision. If a notification has not already been given, the Chief Executive Officer or the National Hospitals Operations Manager will make a determination whether notification should now occur based upon the Relevant considerations for notification to an external agency as set out in these By-Laws relating to the decision under appeal.

## **Part C — Accreditation of Dentists**

### **14. Accreditation and Scope of Practice of Dentists**

- 14.1 By-Laws 7 to 13 are hereby repeated in full, substituting where applicable, Dentist for Medical Practitioner.
- 14.2 Applications for Initial Accreditation and Re-Accreditation should be submitted on the Relevant form to the Hospital CEO/Director of Nursing.

## **Part D— Accreditation of Visiting Allied Health Professionals**

## **15 Accreditation and scope of practice of Visiting Allied Health Professionals**

- 15.1 Clauses 7 to 13 of these By-Laws are hereby repeated in full, substituting where applicable Visiting Allied Health Professional for Visiting Medical Practitioner and Allied Health Professional for Medical Practitioner.
- 15.2 These By-Laws and any associated policies/guidelines will be utilised for an applicant seeking a Scope of Practice as a 'podiatric surgeon'.
- 15.3 Applications for Initial Accreditation and Re-Accreditation should be submitted on the Relevant form to the Hospital CEO/Director of Nursing.

## **15A Accreditation and Scope of Practice of Advanced Practice Nurses**

### **15A.1 Application of By-Laws to Advanced Practice Nurses**

15A.1.1 Subject to clause 15A.1.3 and the modifications set out in this clause 15A, clauses 7 to 13 of these By-Laws apply to Visiting Advanced Practice Nurses in the same manner as they apply to Visiting Medical Practitioners, with the following substitutions and modifications:

- (a) a reference to Medical Practitioner is taken to be a reference to Advanced Practice Nurse;
- (b) a reference to Visiting Medical Practitioner is taken to be a reference to Visiting Advanced Practice Nurse;
- (c) a reference to the Medical Advisory Committee in the context of the Credentialing and Accreditation process is taken to be a reference to a Credentialing Committee constituted in accordance with clause 15A.2;
- (d) a reference to medical registration or registration as a Medical Practitioner is taken to be a reference to registration under the National Law as a Registered Nurse, and in the case of a Nurse Practitioner, current endorsement as a Nurse Practitioner granted by the Nursing and Midwifery Board of Australia;
- (e) the provisions of these By-Laws governing Emergency Accreditation and Temporary Accreditation apply to Nurse Practitioners but do not apply to Perioperative Nurse Surgical Assistants, who may not be granted Emergency or Temporary Accreditation; and
- (f) Mutual Recognition of Accreditation (clause 8.7) applies to Advanced Practice Nurses seeking Accreditation at multiple Cura Hospitals with necessary modifications.

15A.1.2 In respect of a PNSA, clause 13 (Appeal rights and procedure) does not apply. For the avoidance of doubt, all decisions relating to the Accreditation of a PNSA under these By-Laws, including decisions to refuse, amend, suspend, terminate, or impose conditions on Accreditation, are not subject to any right of appeal under these By-Laws.

15A.1.3 To the extent of any inconsistency between this clause 15A and any other part of these By-Laws, this clause 15A prevails in relation to Advanced Practice Nurses.

### **15A.2 APN Credentialing Committee — Composition for Advanced Practice Nurse Applications**

- (a) Where an application for Accreditation under clause 15A.1 is received from an Advanced Practice Nurse, the Hospital CEO/Director of Nursing must, in consultation with the MAC, constitute an APN Credentialing Committee to consider the application.

- (b) The Credentialing Committee constituted under clause 15A.2(a) must include at least:
  - (i) one Accredited Medical Practitioner who practises in a specialty related to the clinical area in which the Advanced Practice Nurse is seeking Accreditation; and
  - (ii) one senior nurse with relevant clinical expertise, which may include (without limitation) the Director of Nursing or an external nominee with expertise in advanced practice nursing.
- (c) The APN Credentialing Committee will assess the application and make a recommendation to the MAC and the Hospital CEO/Director of Nursing in accordance with clauses 7 to 13 as modified by this Part 15A.

### **15A.3 Maintenance of Requirements**

- a) A Visiting Advanced Practice Nurse must maintain at all times:
  - (i) current registration as a Registered Nurse, and in the case of a Nurse Practitioner, current endorsement as a Nurse Practitioner granted by the Nursing and Midwifery Board of Australia;
  - (ii) professional indemnity insurance that expressly covers their approved Scope of Practice and the clinical services they provide at the Relevant Hospital. In the case of a Perioperative Nurse Surgical Assistant, this requirement may be satisfied by the PNSA holding their own professional indemnity insurance that expressly covers their surgical assisting role, or by the PNSA being covered under the professional indemnity insurance of the supervising Accredited Medical Practitioner for the surgical assisting services provided at the Relevant Hospital, provided that in either case the coverage is current, adequate, and verified to the satisfaction of the Hospital CEO/Director of Nursing before Accreditation is granted and at each credentialing cycle; and
  - (iii) compliance with all applicable professional standards, including any standards published by the Nursing and Midwifery Board of Australia relevant to their registration or endorsement.

### **15A.4 Scope of Practice — Nurse Practitioners**

- a) The Scope of Practice approved for a Nurse Practitioner must be consistent with:
  - (i) the Nurse Practitioner's current Nursing and Midwifery Board of Australia endorsement area; and
  - (ii) applicable legislative requirements in the jurisdiction in which the Relevant Hospital is located.
- b) A Nurse Practitioner's approved Scope of Practice may include prescribing rights to the extent permitted by the Nurse Practitioner's Nursing and Midwifery Board of Australia endorsement and applicable State or Territory legislation. Any prescribing rights authorised under a Nurse Practitioner's Scope of Practice must be expressly recorded in the written notification of Accreditation.

### **15A.5 Scope of Practice — Perioperative Nurse Surgical Assistants**

- a) A PNSA is not an independent practitioner.
- b) The Scope of Practice approved for a PNSA must be consistent with:
  - (i) the PNSA's current registration as a Registered Nurse;

- (ii) the relevant professional standards issued by the Australian College of Perioperative Nurses (ACORN) or such other applicable professional body as approved by the MAC; and
  - (iii) applicable legislative requirements in the jurisdiction in which the Relevant Hospital is located.
- c) A PNSA's Scope of Practice does not include independent prescribing, independent diagnosis, or any clinical activity outside the direct supervision of an Accredited Medical Practitioner.
  - d) The Scope of Practice approved for a PNSA may, at the determination of the Hospital CEO/Director of Nursing having regard to the recommendation of the Credentialing Committee, be limited to a particular surgical specialty or to a particular Accredited Medical Practitioner.

#### **15A.6 Relationship to clause 6.2**

- a) A PNSA who holds current Accreditation under this Part 15A and who is acting within their approved Scope of Practice satisfies the requirement in clause 6.2.3 of these By-Laws.

#### **15A.7 Responsibility of Accredited Medical Practitioners for Accredited PNSAs**

- a) An Accredited Medical Practitioner must only utilise the services of an Accredited PNSA who holds current Accreditation at the Relevant Hospital as a Perioperative Nurse Surgical Assistant under these By-Laws.
- b) An Accredited Medical Practitioner who utilises the services of an Accredited PNSA accepts complete responsibility for, and must directly supervise, that PNSA in connection with all clinical activities undertaken by the PNSA within the Relevant Hospital.

#### **15A.8 Treatment Initiation**

- a) Except in the case of emergency, a Visiting Advanced Practice Nurse must not initiate treatment or provide any treatment for any Patient at the Relevant Hospital without the referral or consent of the admitting Accredited Practitioner recorded in the Patient's medical records.

## **Part E — Amending By-Laws, annexures, and associated policies and procedures**

### **16 Amendments to, and instruments created pursuant to, the By-Laws**

- 16.1 Amendments to these By-Laws can only be made by approval of the Board.
- 16.2 All Accredited Medical Practitioners, Dentists, Allied Health Professionals, Podiatric Surgeons will be bound by amendments to the By-Laws from the date of approval of the amendments by the Board, even if Accreditation was obtained prior to the amendments being made. If amendments are to have retrospective application, this must be specifically stated by the Board.
- 16.3 The Chief Executive Officer or the National Hospitals Operations Manager may approve any annexures that accompany these By-Laws, and amendments that may be made from time to time to those annexures, and the annexures once approved by the Chief Executive Officer, or the National Hospitals Operations Manager are integrated with and form part of the By-Laws. The documents contained in the annexures must be utilised and are intended to create consistency in the application of the processes for Accreditation and granting of Scope of Practice.
- 16.4 The Chief Executive Officer or the National Hospital Operations Manager may approve forms, terms of reference and policies and procedures that are created pursuant to these By-Laws or to provide greater detail and guidance in relation to implementation of aspects of these By-Laws.

## 16A Savings and Transitional Provisions

### 16A.1 Prospective operation of amendments

Subject to clauses 16.2 and 16A.4, amendments to these By-Laws operate prospectively from the date of their approval by the Board, or such later date as the Board specifies, and bind all Accredited Practitioners from that date.

### 16A.2 In-train processes

- a) Unless the Chief Executive Officer otherwise determines in writing, any of the following that was commenced under a prior version of these By-Laws and remains on foot at the date of commencement of an amended version of these By-Laws may be continued and finalised under the prior version as if it remained in force for that purpose:
  - (i) an application for Accreditation, Re-Accreditation, Mutual Recognition, Temporary Accreditation, or Emergency Accreditation;
  - (ii) a review of an Accredited Practitioner's Accreditation or Scope of Practice (whether internal or external);
  - (iii) an investigation, suspension, or termination process; or
  - (iv) an appeal.
- b) A determination by the Chief Executive Officer to apply the amended version to an in-train process must be made in writing with written reasons, and the affected practitioner must be given written notice and a reasonable opportunity to respond before the amended version is applied to that process.

### 16A.3 Validation of prior acts

An act, decision, recommendation, appointment, delegation, committee constitution, notice, or procedural step that was validly taken or made under a prior version of these By-Laws is taken to have been validly taken or made for all purposes under these By-Laws, including for the purposes of any in-train process continued under or after the commencement of an amended version.

### 16A.4 Operation regardless of when issue arose

Subject to clause 16A.2, these By-Laws, as in force from time to time, apply to any issue, circumstance, or matter regardless of when that issue, circumstance, or matter arose, including at a time when a prior version of these By-Laws was in force.

## 17 Audit and Compliance

- 17.1 The Hospital CEO/Director of Nursing will establish a regular audit process, at intervals determined to be appropriate by the Hospital CEO/Director of Nursing or as may be required by a regulatory authority, to ensure compliance with and improve the effectiveness of the processes set out in these By-Laws relating to Credentialing and Accreditation, and any associated policies and procedures, including adherence by Accredited Practitioners to approved Scope of Practice.
- 17.2 The audit process will include identification of opportunities for quality improvement in the Credentialing and Accreditation processes that will be reported to the Chief Executive Officer or the National Hospitals Operations Manager.