Policy No: **Portfolio**: Clinical Governance

Policy Title:
Credentialing and Defining Scope of Clinical Practice Policy

Policy Statement:
This policy aims to provide an effective and comprehensive structure for St Vincent's Health Australia (SVHA) to ensure all defined health professionals are credentialed and have a defined scope of clinical practice to support the delivery of safe and high quality care by appropriately qualified professionals whose performance is maintained at an acceptable level.

Applicable to:
This policy applies to all clinical staff and clinical service providers in SVHA Divisions and Facilities as defined in this document.

Relationship to Delegations Manual:
Pursuant to Delegation Item E12 of the SVHA Delegations Manual, Version 3 October 2013, this policy requires approval by the SVHA Board.

Respect the Mission and Values of SVHA:
The Credentialing process reflects the expectations of our patients, clients or residents to continuously improve health outcomes in line with our mission and values.

Legal and Compliance Considerations:
Must comply with jurisdictional policy and legislation including:

1. Health Practitioner Regulation National Law Act 2009
2. Queensland - Health Practitioner Regulation National Law Act 2009
3. Queensland - Health Ombudsman Act 2013
4. New South Wales - Health Practitioner Regulation No 86a
5. Victoria - Health Practitioner Regulation National Law (Victoria) Act 2009

Relevant References:

1. National Safety and Quality Health Service Standards (NSQHSS) – Standard 1.10 – Implement a system that determines and regularly reviews the roles, responsibilities, accountabilities and scope of clinical practice for the clinical workforce
2. Credentialing health practitioners and defining their scope of clinical practice: A guide for managers and practitioners. Australian Commission on Safety and Quality in Health Care (ACSQHC) December 2015
3. SVHA Group Model By-Laws
4. SVHA Pre Employment Appointment Safety Screening Checks Policy
5. SVHA Code of Conduct

Review Officer:
Group General Manager Clinical Governance and Chief Medical Officer

Date Introduced:
February 2012

Updated:
16th August 2012, 1 August 2013, 12 December 2013, June 2017

Next Review Date:
May 2020

Approval:
Chair SVHA Board

1 June 2017

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Signature: Date:

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BACKGROUND

St Vincent's Health Australia (SVHA), its employees and visiting health professionals, have a legal and moral obligation to ensure that services are provided in circumstances where patient safety and quality of care has been properly addressed. Credentialing and defining the Scope of Clinical Practice are essential components of a broader system of organisational management of relationships with health professionals, clinical governance and health service accreditation. This includes those who provide clinical services and clinical support services, those who supervise staff and students, and those in professional leadership roles (head of department or equivalent).

It is essential to ensure the provision of services is safe and of high quality by ensuring:

- Services are provided within the capability and needs of the health service and its respective sites.
- Health professionals appointed to practice at a health service are competent and able to fulfil all tasks and responsibilities associated with their role.
- Recognition by boards of health services of their responsibility to establish and maintain systems that will ensure services provided are within the scope of a health professionals practice.

Where health services are provided by an external contractor, the employing Agency is responsible for ensuring the credentialing of the health professionals. Local memorandums of understanding with these agencies need to include this requirement.

PURPOSE

This policy is to ensure:

- All identified health professionals are credentialed and have a defined scope of clinical practice
- Systems and processes are in place to ensure that where a breach of credentialing / registration or scope of clinical practice is identified as a contributing factor to an incident or near miss that appropriate notification is made in accordance with the SVHA By-laws and local jurisdictional requirements
- Clinicians are afforded natural justice and the right to appeal decisions made regarding their scope of clinical practice.

This policy is to be read in conjunction with the SVHA By-Laws. The SVHA By-Laws currently apply to Accredited Practitioners only. The scope of this Policy extends to all Clinicians who provide health services within SVHA Facilities.

GOVERNANCE

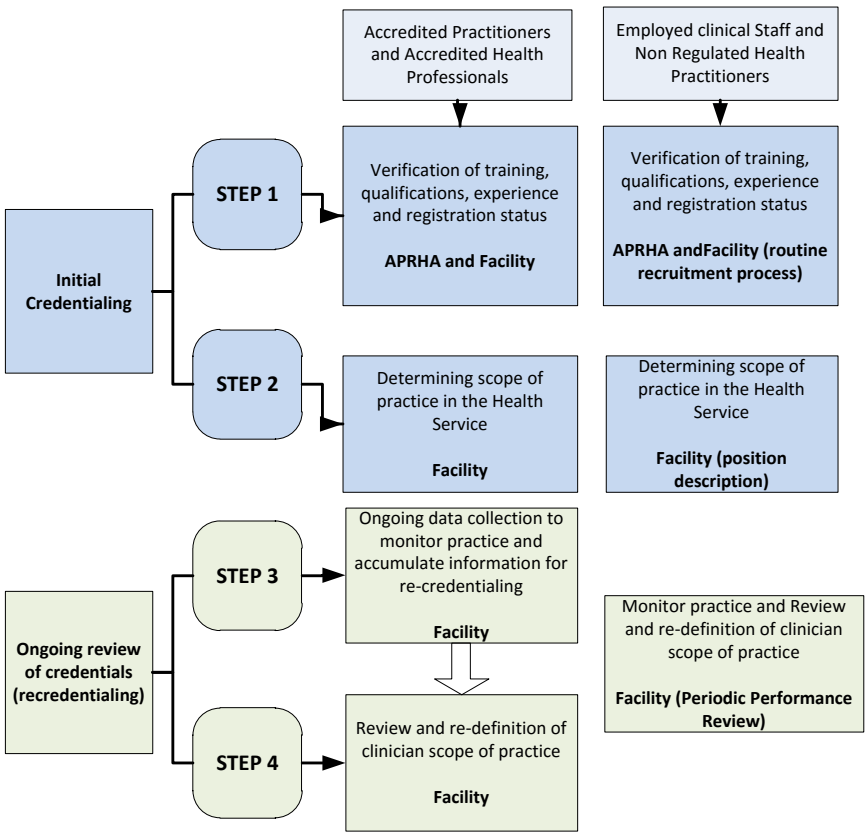
To achieve an effective governance system for Credentialing and defining the Scope of Clinical Practice **all SVHA Facilities must:**

1. Follow a standard Credentialing process

For all accredited health professionals in any practice situation, Credentialing commences during the recruitment or application process (qualification verification) then on Appointment (initial Credentialing) and continues for the term of employment (ongoing Credentialing or Re-credentialing). The process has four steps; two relate to the initial Appointment, and two to the ongoing review of Credentials. Although the majority of the work done concerns ongoing Credentialing, the four steps are considered equally important in clinical quality management. See figure 1 below.

The management of this process may vary across divisions depending on local circumstances, however the process must be documented, agreed with accredited practitioners, healthcare professionals, employed clinical staff and non-regulated health practitioners, consistent with the jurisdictional requirements, the SVHA By-laws and the ACSQHC Credentialing Guide and open to audit.

Figure 1 – the 4 step credentialing process



The Scope of Clinical Practice agreed with an Accredited Health Professional/Accredited Practitioner, employed clinical staff and/or non-regulated health practitioner at the time of Appointment, is developed within the context of the service in which the clinician is appointed. It is specific to the Facilities named and support available at a specified period and to the service the organisation is approved to provide. For employed nursing, allied health, junior medical, Assistants in Nursing (AIN) and Personal Care (PC) staff, the Scope of Clinical Practice is defined by their position description.

2. Ensure appropriate clinical governance

2.1 Each Facility Chief Executive Officer (FCEO) is responsible for establishing the range of clinical services, procedures and other interventions that can be provided in their Facility/Facilities in line with Organisational Capabilities, Organisational Need, role delineation guidelines (public hospitals) and licensing agreements (private hospitals and aged care services).

2.2 All Accredited Health Professionals/Accredited Practitioners, and non-regulated health practitioners, including locums and agency staff, who have independent responsibility for patient care and are appointed to SVHA Facilities must be appropriately credentialed.

2.3 All Accredited Health Professionals/Accredited Practitioners and non-regulated health practitioners must have their Scope of Clinical Practice defined in accordance with both their level of skill and experience and the Organisational Capabilities and Organisational Need of the Facility.

2.4 It is a professional responsibility to report competence issues, both personal and peer related to AHPRA as defined by local and jurisdictional requirements. This includes mandatory and voluntary reporting.
2.5 For non-regulated health practitioners significant competence issues must be referred to the respective jurisdictional health care complaints authority.

3. Ensure integration with the broader governance system of SVHA

3.1 Credentialing and defining the Scope of Clinical Practice of Clinicians is compliant with the SVHA By-Laws, all relevant legislation (including but not limited to legislation relating to employment, anti-discrimination, health records and privacy), SVHA Human Resources policies and processes (Group and Divisional) and all jurisdictional guidelines and directives.
3.2 Systematic issues arising from the Credentialing and Scope of Clinical Practices processes that require consideration the FCEO's are reported to the SVHA Group Chief Medical Officer who provides advice to the SVHA Group CEO as and when required.
3.3 Issues that require consideration at a SVHA Board level including suspensions, terminations of medical or complaints by medical practitioners regarding the credentialing process that require Board discussion are reported to the Board Quality and Safety Committee via the SVHA Group Chief Medical Officer.

4. Ensure appropriate committees are in place to manage Credentialing and defining the Scope of Clinical Practice

4.1 These committees are responsible for undertaking the process of Credentialing and defining the Scope of Clinical Practice. For many, nursing, allied health and junior medical staff positions, this may be part of the recruitment and appointment processes of the Facility.
4.2 Any potential conflict of interest should be declared and documented.
4.3 External expertise may be co-opted to the committee eg specialist medical college, Australian College of Nursing.

PROCESS FOR INITIAL CLINICAL CREDENTIALING

To establish effective processes for clinical credentialing **all SVHA Facilities must:**

5. Verify minimum credentials

The facility must obtain and review evidence that the practitioner has attained the minimum credentials required for the scope of clinical practice of the position to be filled. This includes:

5.1 Qualifications accepted for registration by the relevant national board
5.2 Details of recognised postgraduate awards, fellowships and certificates that demonstrate successful completion of training from relevant college, association or training institution
5.3 Evidence of relevant clinical activity, practice and experience in similar settings in which the scope of clinical practice is being sought
5.4 Ensure all individuals, at the time of interview, provide appropriate documentation to satisfy the 100 point ID check and note in writing that the individual's identity was confirmed.
5.5 Ensure a criminal record check is undertaken on all new Accredited Health Professionals/Accredited Practitioners and non-regulated health practitioners with a responsibility for patient care.
5.6 Ensure a "working with children" check is undertaken for all Accredited Health Professionals/Accredited Practitioners and non-regulated health practitioners providing clinical care in paediatric areas.

5.7 Where applicants do not have a professional registration body, or are new graduates, evidence of professional development and continuing professional education (CPE) or continuing professional development (CPD) records must be provided

6. Complete reference and referee checks

6.1 At least two current references must be obtained. References must be obtained from people who have observed and therefore have first-hand experience of the applicant's work or people who have assessed clinical data relating to the competence of the applicant

6.2 At least one referee must be from either a head of the speciality, direct line manager or equivalent at the institute where the applicant most recently practiced or within or directly relevant to the field of practice in which the applicant will practice.

7. Undertake pre-registration, professional indemnity and other documentation checks

7.1 A minimum requirement for appointment / accreditation and continuing appointment / accreditation is evidence of current registration with the relevant national board

7.2 Evidence of current professional indemnity insurance including coverage relating to specific scope of clinical practice is required for all accredited practitioners working at SVHA

7.3 The following additional documentation form part of the appointment / accreditation process:

- Current curriculum vitae
- Declaration covering existing or previous restrictions or conditions on their registration, criminal history, professional misconduct, unsatisfactory professional conduct or outstanding complaints
- Proof of identity – 100 point ID check
- Passport and copies of relevant visas for overseas trained clinicians
- Police check for all new appointments / accreditation
- Working with children check for all clinicians working with children

DEFINE THE SCOPE OF CLINICAL PRACTICE FOR ACCREDITED PRACTITIONERS

8. Defining the initial scope of clinical practice will require the following:

8.1 Evidence from the clinician they have the required credentials and demonstrate competence as outlined above

8.2 An organisational needs assessment including staffing levels, skill mix, clinical services and level of support services are endorsed by management

9. Determining core scope of clinical practice (Tier 1)

9.1 Each applicant must select a 'core scope' of practice from the list in the e-Credentialing system. The 'core scope' refers to those aspects of clinical practice that can reasonably be expected to be undertaken by all clinicians holding a particular qualification, having successfully completed the education and training to that qualification

9.2 The facility credentialing committee needs to assess the degree of competence based on the time since the qualification was completed and the clinician's subsequent practice experience

9.3 The inclusion or exclusion of core clinical practice responsibilities should be documented and monitored as part of annual performance reviews

10. Determining advanced scope of clinical practice (Tier 2)

10.1 Applicants applying for advance scope or Tier 2 credentials will need to provide evidence of:

- Training and supervised practice in the specific area
- Evidence of relevant experience
- References from at least two clinicians with direct knowledge of the applicant's clinical abilities in the specific area
- Membership of a professional group or sub-speciality.

10.2 Consideration should be given to the requirements of the national board's recency standard when assessing these applications

10.3 To be granted extended scope of clinical practice the training and competence in that procedure should match the requirements for that specific clinical practice and be consistent with the relevant college or professional body

11. Scope of clinical practice - temporary or short-term appointments

Temporary or interim scope of clinical practice may be required for clinician' engaged on short-term contracts of commencing prior to the credentialing committee convening. The clinician's credentials will be assessed by the relevant professional leader or their delegate and appointment/ accreditation made for a specified scope of practice. In these cases the following is required:

11.1 Verification of credentials
11.2 Confirmation of scope of clinical practice
11.3 Requirements for clinical oversight / supervision or review of performance data

All relevant information must be documented in the e-Credentialing system (only employed / salaried staff information will be collected in the HRIS system)

12. Emergency situations

Occasions may arise for any individual clinician to perform a therapeutic activity in a life-threatening emergency where the risk of delay and or transfer substantially increases the risk of harm for a consumer. Under these circumstances approval must be granted by the relevant professional leader or delegate. Where time allows, the credentials of the clinician should be verified by at least one current peer. Once the critical incident has passed, the matter must be fully documented in the e-Credentialing system

13. Ensure the principles of procedural fairness and natural justice apply

13.1 No application for Credentialing or Scope of Clinical Practice determination is to be decided upon or influenced by gender, ethnicity, nationality/national origin, religious beliefs or sexual orientation. All clinical appointments are to be made on merit. This requires that the person selected has the ability, qualifications, experience, work performance and personal attributes that meet the Facility's needs.

13.2 Members of committees participating in the Credentialing and defining Scope of Clinical Practice processes must ensure that any personal information obtained related to the applicant is kept in confidence.

13.3 Individuals should receive feedback on any unsuccessful application or variation in Scope of Clinical Practice but are not privy to the notes and documentation of the committee other than where so required by law.

13.4 Meeting outcomes must be clearly documented and open to audit and provide assurance to the Divisional Chief Executive Officer of the robust nature of the process, subject to any statutory immunity considerations.

RE-CREDENTIALING / RENEWAL OF SCOPE OF CLINICAL PRACTICE FOR ACCREDITED PRACTITIONERS

Renewal of scope of clinical practice involves assessing any changes in the clinician's credentials, considering any restrictions that may be in place and confirming the service provision and organisational capabilities. Scope of clinical practice can be renewed (without change) or amended. This should occur at a minimum of every three years.

14. Renewing scope of clinical practice

The following information should be requested and provided by each Clinician whose credentials are under review for any reason:

14.1 Evidence of current professional registration (where available)
14.2 Evidence of type and scope of current professional indemnity insurance (not required for employed staff indemnified directly by the Facility)
14.3 Maintenance of training and professional requirements including continuing professional development
14.4 Ongoing competency of clinical practice demonstrated by clinical audit data, peer review and any related incident reports
14.5 Participation in performance reviews where process and outcome of the process is documented and available to the credentialing committee
14.6 Regular attendance at relevant clinical meetings as specified by the facility.
14.7 Any complaints, compliments or adverse professional or criminal record
14.8 Any other information requested by the facility.

15. Renewal of specific scope of clinical practice

In addition to core scope requirements, renewal of specific / extended scope may include:

15.1 Evidence of proficiency in performing a specific procedure
15.2 Successful participation in clinical audit
15.3 Ongoing professional development
15.4 Participation in organisational quality and safety activities including clinical incident reviews and mortality and morbidity meetings etc.

16. Establish a process for review of Scope of Clinical Practice

16.1 Review of Scope of Clinical Practice may be planned or unplanned.
16.2 Planned review of Scope of Clinical Practice must be undertaken for all Accredited Health Professionals/Accredited Practitioners and includes oversight of ongoing service competence monitoring (this may be part of an annual performance review process or Re-credentialing process). For nursing, this relates to Nurse Practitioners.
16.3 Scope of Clinical Practice for a new Appointment will be reviewed at the end of the first year of appointment and thereafter at least every three years or as determined by the facility.
16.4 Unplanned review of Credentials and Scope of Clinical Practice may be required where there is a complaint or concern raised about a Clinician. This will be as per the performance review processes articulated in Human Resource policies and procedures.

17. Data collection to monitor medical professional practice

Depending on the specialty, the medical college or specialist society may have very specific criteria required for review of ongoing competence at the time of Re-credentialing and confirming Scope of Clinical Practice.

These may include, but not be limited to:

17.1 Details of involvement in any clinical audits or peer review activities.
17.2 Where relevant, a summary of clinical activity undertaken, including the approximate number, type, procedures or other interventions performed, consultations undertaken.
17.3 Where available, objective data on the outcomes of the above clinical activity.
17.4 Other relevant information, such as incidents, complaints and patient satisfaction.
17.5 Patient satisfaction in professional interaction and clinical service provision.
17.6 Documented feedback from other health professionals.

18. Appeals in relation to re-credentialing decisions for all Accredited Health Professionals/Accredited Practitioners

18.1 Have an appeals or equivalent committee constituted according to By-Law 19.

18.2 Ensure all information is considered and the recommendations are made on the basis of that information.

18.3 Recommendations and reasons for reaching them are documented and provided in writing to the SVHA Group Chief Medical Officer within 90 days of being notified of the appeal.

NURSING AND ALLIED HEALTH PROFESSIONALS

This section applies to all Eligible Midwives, Nurse Practitioners and Allied Health staff with independent responsibility for patient care or clinical supervision across SVHA and provides guidance for a uniform system of credentialing and defining the scope of clinical practice. All other staffs roles and responsiblities are covered under relevant position descriptions / duty statements.

19. Eligible Midwives

Eligible midwives must be entitled to the endorsement under section 98 of the National Law and be able to demonstrate:

19.1 Practice for at least three years across the continuum of midwifery care, within the previous 5 years

19.2 Successful completion of an approved professional review program for midwives working across the continuum of midwifery care

19.3 Completed an accredited prescribing course as determined by the Australian Nursing and Midwifery Accreditation Council.

20. Nurse Practitioners

Nurse Practitioners must be entitled to the endorsement under section 98 of the National Law if they hold either of the following qualifications relevant to the endorsement:

20.1 An approved qualification.

20.2 Another qualification that, in the opinion of the Nursing and Midwifery Board of Australia is substantially equivalent to, or based on similar competencies to, an approved qualification.

20.3 Comply with any approved registration standard relevant to the endorsement.

21. Peri-operative Surgical Nurse Assistants (PSNA's)

The PNSA role is an advanced practice nursing role. The PNSA role encompasses the preoperative, intraoperative and postoperative phases of care. During the intraoperative phase the PNSA is required to perform the function of first assistant to the surgeon. The PNSA collaborates at all times with the patient, other nurses, medical officers and allied healthcare workers to ensure quality care and outcomes for the patient. As an emerging role in Australia, the PNSA may be employed by a surgeon, SVPH or independently employed.

- The PNSA is a perioperative nurse with additional education and skills, functioning in an expanded role
- The PNSA practises perioperative nursing and has acquired the knowledge, skills and judgement necessary to assist the surgeon, through organised instruction and supervised practice
- The PNSA functions interdependently with the surgeon during the intraoperative phase of practice
- The PNSA does not concurrently function as an instrument nurse
- The PNSA functions under the direct supervision of the surgeon during the intraoperative phase.

21.1 The PNSA must have a post-graduate qualification from a PNSA education facility
21.2 The PNSA must undergo a credentialing process before being granted clinical privileges (this can be the MAC or equivalent committee)

22. Allied Health professionals (AHP's)

SVHA is committed to ensuring that all AHPs have the appropriate and recognised credentials to provide services relevant to their area of professional responsibility. This is an essential platform for the safety and best care of patients and consumers.

For initial credentialing, original documents are to be sighted and primary sources are to be contacted to verify documentation for self–regulated professions.

For registered professions, AHPRA has responsibility for verification and demonstration of current unrestricted registration status.

23. Registered Professions

23.1 These professions are legislated to meet the requirements of registration, a outlining a minimum standard of training in a particular field.
23.2 Registration is through the relevant professional board of the AHPRA. AHPs that require registration are not permitted to practise in clinical or clinical supervisory roles without being registered with their respective Board via AHPRA. For non-clinical roles, AHPs must be eligible for membership of the professional association and hold an appropriate degree or equivalent qualification which entitles registration.

24. Self-regulated Professions

Following qualification from an accredited University course or training program, AHPs within clinical, clinical supervision or non-clinical roles will be eligible for membership of their professional association, which sets and maintains standards of practice. Being eligible for membership provides evidence that an individual has completed a minimum standard of training in a particular profession. Participation in an accredited continuing professional development program (where available) is desirable as part of professional association membership.

25. Verification Process for nursing and allied health professionals

25.1 Health services must ensure to verify a health professionals credentials and the verification process must be rigorous.
25.2 The health service must ensure the health professional is who he/she says they are, and is presenting bona fide documentation.
25.3 If a health service uses a recruitment agency to source applicants, the health service is still responsible for undertaking its own verification process

Appendix 1 - RESPONSIBILITIES

SVHA facilities have overall responsibility for service provision and executing this Policy at the local level. This is achieved through:

- Clearly identifying the limits of individual accountability
- Ensuring a mechanism for the oversight of accountability that is plainly articulated and well communicated to staff
- Ensuring there are relevant committees to manage the process whose roles are clearly defined.

1. Applicant

1.1 Ensuring all requested information is provided within the required timeframes.

1.2 Disclosing the status of registration including any conditions, past or present suspensions, reprimands or undertakings, limitation on Scope of Clinical Practice by another facility (including external to SVHA) or any other matter that the committee could reasonably expect to be disclosed in order to make an informed decision on Credentials and Scope of Clinical Practice.

1.3 At all times act in good faith.

2. Facility Chief Executive Officer (FCEO)

2.1 Ensuring that all Clinicians in each facility are registered and if relevant are credentialed and granted Scope of Clinical Practice in accordance with the SVHA By-Laws and Credentialing and Defining Scope of Clinical Practice Policy.

2.2 Ensuring all records are maintained in the e-Credentialing system and those records are available for audit.

2.3 Ensuring the letter advising the applicant of a decision made is dispatched to the applicant within 14 business days of the date of FCEO approval with a copy of the correspondence retained on record.

2.4 The FCEO will consult with the SVHA Group Chief Medical Officer regarding any issues arising from the credentialing process, including prior to a decision to suspend or terminate the appointment of an Accredited Practitioner.

2.5 Providing training and support to Committee members including information on:

- Credentialing policies and process
- Roles and responsibility of committee members
- Documents submitted from the applicant requiring review
- Process for assessing credentials and verifying the information
- Process for identifying organisations capability and agreed service provision

3. Credentialing Committee

3.1 Must comply with the SVHA By-Laws.

3.2 Chair must have extensive experience and skills in credentialing and defining scope of clinical practice processes

3.3 Committee must follow the terms of reference outlined Schedule 2 of the SVHA By-laws

3.4 Must conduct their responsibilities to a high standard and in a timely manner. Meetings of the committee should be conducted regularly as defined by each jurisdiction.

3.5 The chairperson may convene an extraordinary meeting where, in the opinion of the chairperson, a matter should not reasonably wait for the next scheduled meeting of the committee

3.6 When reviewing scope for the introduction and oversight of new technology, equipment, procedures and treatments, the committee may require evidence of appropriate clinical supervision to fulfil scope of clinical practice

3.7 All discussions, deliberations and decision must follow the process and the principles of procedural fairness

3.8 Proceedings should always be fair and transparent.

4. SVHA Group Chief Medical Officer

4.1 Analyse and critique issues related to Credentialing and defining Scope of Clinical Practice and provide advice to the SVHA Group Chief Executive Officer and Group Executive to resolve or escalate any issues arising.

4.2 Provide advice to the Board on issues related to suspension, termination or appeals arising from the Credentialing process

5. The SVHA Board Clinical Governance And Safety Committee

The committee will:

5.1 Maintain oversight of Divisional/Facility based committees (including Appointments, Credentialing, Scope of Clinical Practice and appeals committees, or equivalent committees) and provide a forum for advice on issues of a complex credentialing nature and review credentialed Accredited Practitioner suspensions and terminations or complaints in order to advise the Board from a risk management perspective.

6. The Board

The Board, and the Board Quality and Safety Committee, must ensure the safety and quality of services provided for patients, clients or residents. The Board has ultimate responsibility for the clinical governance of its health service. In achieving effective clinical governance the Board's role in clinical Credentialing and defining the Scope of Clinical Practice includes:

6.1 Ensuring appropriate systems are in place that support robust Credentialing and defining Scope of Clinical Practice.

6.2 Ensuring organisational accountability is clearly articulated and FCEO's, senior managers and Clinicians understand and enact their responsibilities.

6.3 Being satisfied that there is compliance with relevant legislation, regulations and standards.

6.4 Where an Accredited Practitioner makes an appeal against a decision to amend, make conditional, suspend, terminate, not renew or conditionally renew his or her Appointment in writing to the FCEO the Board will (according to By-Law 19)

6.5 Nominate a member of the board to participate in a committee established by the FCEO to hear the appeal.

6.6 Nominate the chairperson of the appeals committee.

6.7 Consider the written recommendation of the appeals committee and make a decision.

6.8 The decision of the Board regarding appeals will be final and binding.

APPENDIX 2 - DEFINITIONS

Accredited Health Professional means an Allied Health Professional, Independent Midwife, Perioperative Nurse Surgeon's Assistant, Nurse Practitioner, Dental Assistant, Complimentary Medicine Practitioner or Other Health Professional authorised to treat patients at a Facility in accordance with specified Scope of Clinical Practice and any specified conditions.

Accredited Practitioner means a Medical Practitioner or Dental Practitioner authorised to treat patients at a Facility in accordance with a specified Accreditation Classification and Scope of Clinical Practice.

ACSQHC Credentialing Guide refers to the Credentialing health practitioners and defining their scope of clinical practice: A guide for managers and clinicians December 2015

AHPRA means the **Australian Health Practitioner Registration Agency** established under the *Health Practitioner Regulation National Law Act 2009*, which came into effect on 1 July 2010. It is the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia. Each health profession that is part of the Scheme (currently 10) is represented by a National Board regulated by nationally consistent legislation. These National Boards are:

1. Aboriginal and Torres Strait Islander Health Practice Board of Australia
2. Chinese Medicine Board of Australia
3. Chiropractic Board of Australia
4. Dental Board of Australia
5. Medical Board of Australia
6. Medical Radiation Practice Board of Australia
7. Nursing and Midwifery Board of Australia
8. Occupational Therapy Board of Australia
9. Optometry Board of Australia
10. Osteopathy Board of Australia
11. Pharmacy Board of Australia
12. Physiotherapy Board of Australia
13. Podiatry Board of Australia
14. Psychology Board of Australia

Appointment means the employment or engagement of a Clinician to provide services within a Facility according to conditions defined by general law and supplemented by a contract of employment or letter of engagement and prevailing internal policies.

Board means the Board of Directors of SVHA.

Board Quality and Safety Committee means a committee established by the Board to ensure systems are in place and are being monitored for the purposes of providing information to the Board so that the Board can assess and determine whether in respect of SVHA Group Entities and Facilities:

(a) all clinical risks are being appropriately managed;
(b) safe, quality clinical care is being provided to patients, clients or residents; and
(c) a culture of clinical quality improvement is being fostered and is inherent

Chief Executive Officer means either or all of the following as applicable and specified at any time within these By-Laws:

(a) the SVHA Group CEO;

(b) the Divisional CEO (DCEO)

(c) the Facility CEO (FCEO).

Clinical Leader / professional clinical leader / head of department means head of a particular department. This could be the director of a service–ie a specialty field–eg, surgery, whose function is to foster, facilitate, and participate in institutional activities, coordinate departmental activities, maintain the quality of care rendered by the department, arbitrate intradepartmental disputes and interact with administration, nursing, and other departments

Clinician means a person involved in the area of clinical practice, including without limitation, diagnosis, care and treatment, whether through direct or indirect patient/client contact.[1]

Competence means the combination of knowledge, skills, abilities and attributes that are required for a person to be successful in a role[3]

Credentialing means the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of health practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific Facility environments[2].

Credentials means the practical experience, qualifications, professional awards and statements of competency issued by an authorised and recognised body that attest to a practitioner's education, training and competence and relevant practical experience[3].

Divisional CEO (DCEO) means the chief executive officer of the relevant Division of SVHA being either:

(a) the CEO of the Public Hospitals Division;
(b) the CEO of the Private Hospitals Division;
(c) the CEO of the Aged Care and Shared Services Division.

Facility means hospital, aged care facility or day procedure centre conducted by a SVHA Group Entity in which health services and aged care are provided.

Facility CEO (FCEO) means the following chief executive officer which report to a DCEO:

(d) Chief Executive Officer of St Vincent's Hospital Melbourne;
(e) Chief Executive Officer of St Vincent's Health Network Sydney;
(f) Chief Executive Officer of St Vincent's Private Hospital Melbourne (including Kew, East Melbourne & Fitzroy);
(g) Chief Executive Officer of St Vincent's Private Hospital Sydney;
(h) Chief Executive Officer of Mater Hospital North Sydney;
(i) Chief Executive Officer of St Vincent's Private Hospital Griffith.
(j) Chief Executive Officer of Holy Spirit Northside Private Hospital;
(k) Chief Executive Officer of St Vincent's Private Hospital Brisbane;
(l) Chief Executive Officer of St Vincent's Private Hospital Toowoomba

Health practitioner means a person eligible for registration with a national board as well as self-regulated practitioners eligible for registration with their national bodies and associations including speech pathology, social work, exercise physiologists, audiologists and dieticians.

Independent responsibility for patient care means a clinician not working under direct supervision

New clinical services, procedures, or other intervention (including medical or surgical procedures, and the use of prostheses and implantable devices or diagnostic procedures) that is considered by a reasonable body of medical opinion to be significantly different from existing clinical practice. It includes a procedure that has not been performed at the Facility, as well as variations to an existing procedure or treatment where a new device or item of equipment is introduced.

Non-regulated health practitioner means one whose profession is not registered or subject to regulation by the Australian Health Practitioner Regulation Agency. For example, social workers, acupuncturists, massage therapists, Assistant in Nursing, Personal Care Staff.

Notifiable Conduct pursuant to the *Health Practitioner Regulation National Law Act 2009,* in relation to a registered health practitioner means the practitioner has –

[1] Australian Institute of Health and Welfare
[2] Credentialing health practitioners and defining their scope of clinical practice: A guide for managers and practitioners ACSQHC December 2015

(a) Practised the practitioner's profession while intoxicated by alcohol or drugs; or
(b) Engaged in sexual misconduct in connection with the practice of the practitioner's profession; or
(c) Placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or
(d) Placed the public at risk of harm because the practitioner has practiced the profession in a way that constitutes a significant departure from accepted professional standards.

Organisational Capabilities means the Facility's ability to provide facilities, services and clinical and non-clinical support necessary for the provision of safe, high quality clinical services, procedures or other interventions.

Organisational Need means the extent to which the Facility elects to provide a specific clinical service, procedure or other intervention in order to provide a balanced mix of safe, high quality health care services that meet patient and community need and expectation. This will include consideration of the strategic, operational and business plans, goals and objectives of the organisation.

Proof of identity means applicants for registration must provide sufficient evidence of their identity as per the Australian Health Practitioners Registration Authority (AHPRA) guidelines.

Re-credentialing[3] is the formal process used to re-confirm the qualifications, experience and professional standing (including history of and current status with respect to professional registration, disciplinary actions, indemnity insurance and criminal record) of Clinicians for the purpose of forming a view about their ongoing competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments.

Registrar means a medical practitioner who is participating in a recognised training program for qualifying as a specialist practitioner with one of the medical colleges.

Scope of Clinical Practice means the process following on from Credentialing and involves delineating the extent of an individual Clinician's clinical practice within a particular Facility, based on the individual's credentials, competence, performance and professional suitability and the needs and capability of the Facility to support the Clinician's Scope of Clinical Practice. The term "clinical privileging" has been widely used in the past as an alternative to the phrase "defining the Scope of Clinical Practice". Defining Scope of Clinical Practice minimises the potential for adverse safety and quality consequences which may occur if clinical staff work outside their areas of competence or where the environment does not support safe service provision. For nurses this relates to nurse practitioners and those with an advanced scope.

SVHA means St Vincent's Health Australia Limited ACN 073 503 536.

SVHA Group Chief Executive Officer means the chief executive officer of SVHA as appointed by the Board.

SVHA Chief Medical Officer means the chief medical officer responsible for effective governance of clinical safety and quality outcomes across all SVHA Facilities as appointed by the SVHA Group Chief Executive Officer.

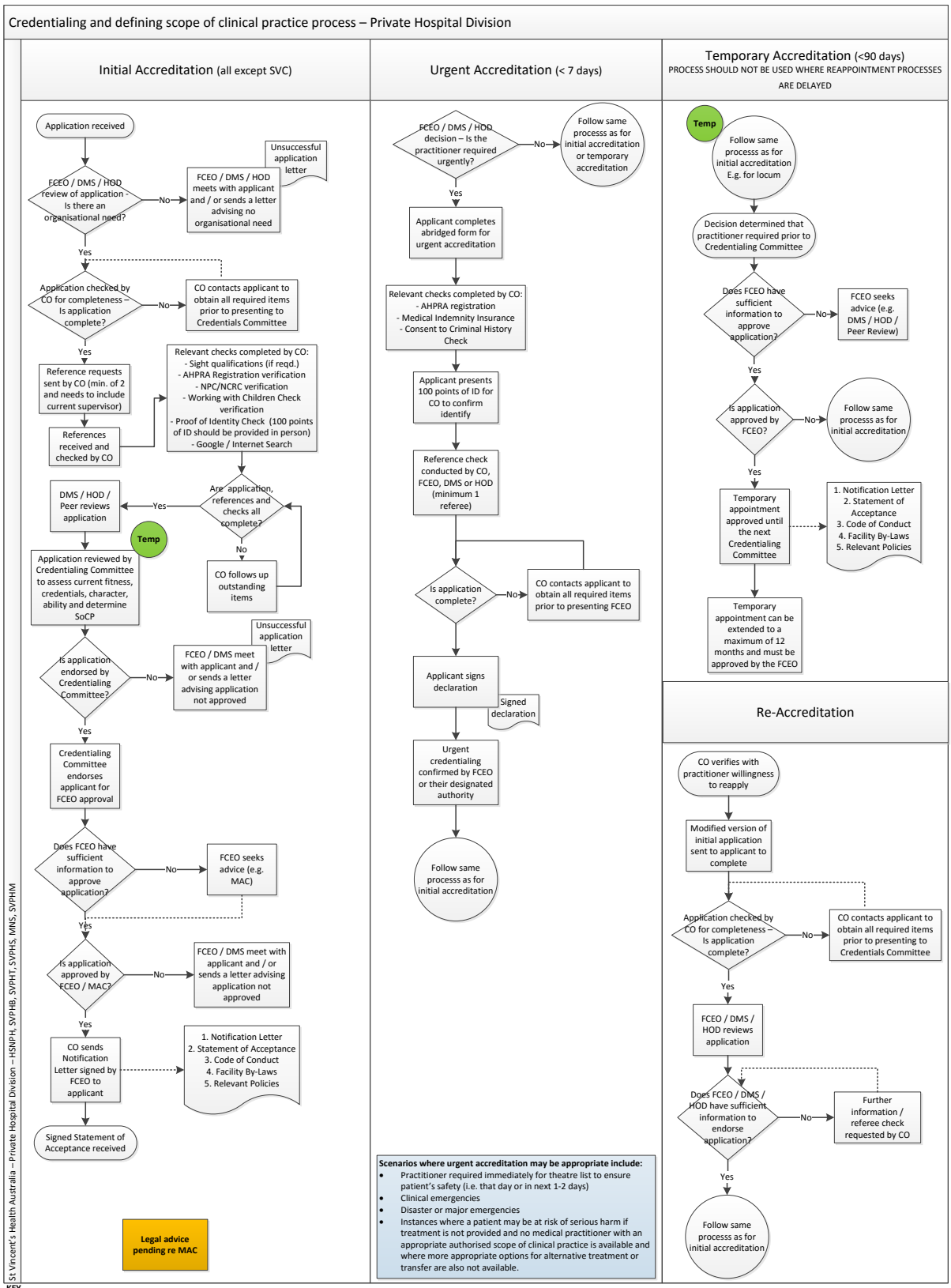
SVHA Group Entity means:

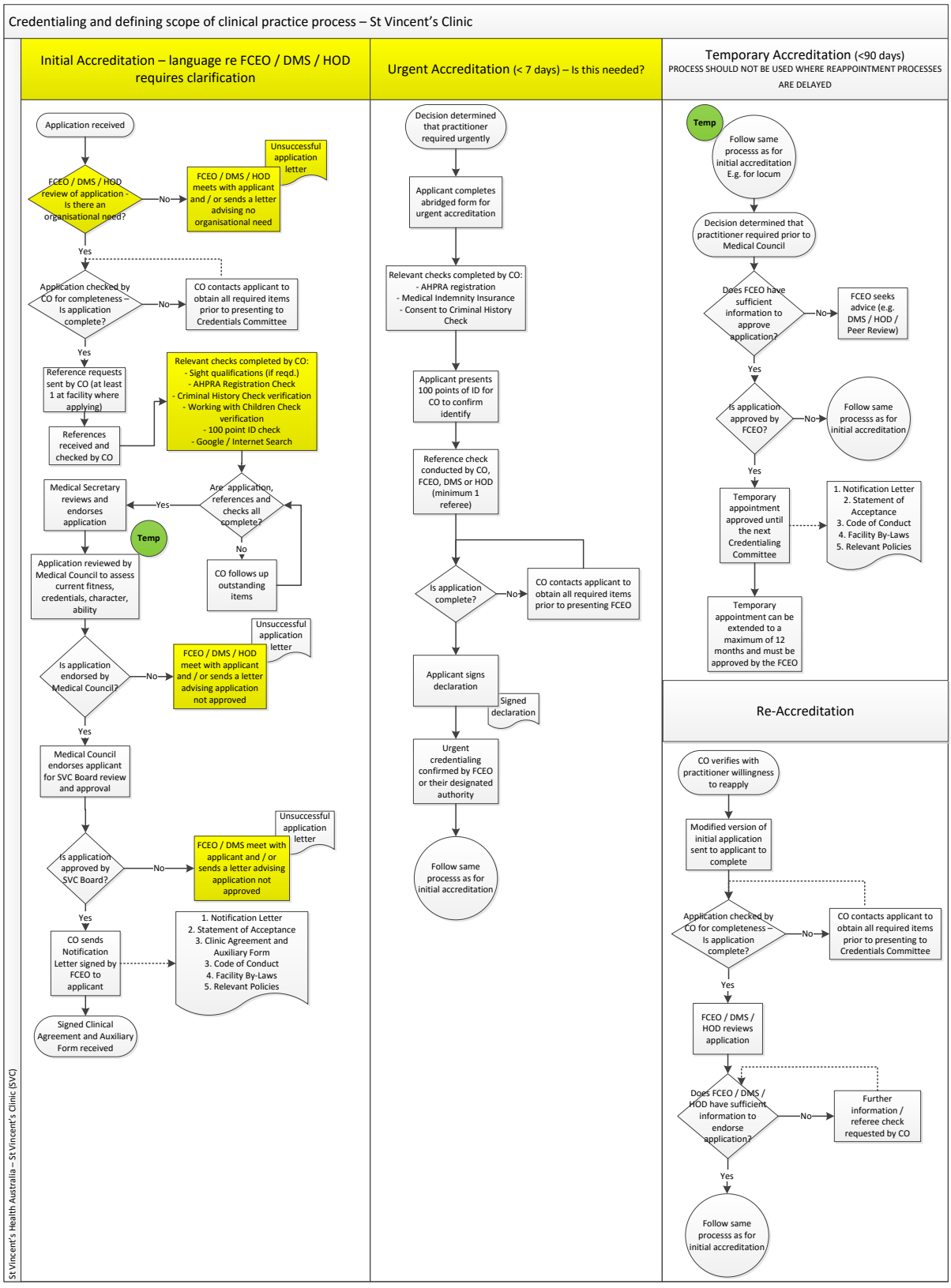
(a) The Division of Public Hospitals
(b) The Division of Private Hospitals

[3] In the case of Accredited Practitioners this process refers to re-accreditation as described in the By-Laws

(c) The Division of Aged Care and Shared Services

APPENDIX 3 – FLOW CHARTS





KEY

FCEO = Facility Chief Executive Officer / General Manager
DMS = Director of Medical Services (or equivalent)
HOD = Head of Department
CO = Credentialing Officer
SVC = St Vincent's Clinic

Temp — If temporary accreditation required refer to Temporary Accreditation process