Accreditation of health practitioners – state-wide procedure

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1. Introduction

This procedure outlines the process for accreditation of a health practitioner providing services at Mater Health. This accreditation process will be in accordance with the Mater Misericordiae Ltd By-Laws for accredited Practitioners (2021) (referred to in this procedure as the By-Laws) to ensure all identified health practitioners are appropriately credentialed and have a defined scope of practice to provide safe and high-quality health care services.

This procedure is to be read in conjunction with the By-Laws.

1.1 Scope and context

Credentialing is a process that aims to verify a health practitioner's qualifications, experience, professional standing and capability to perform work within their Scope of Clinical Practice (SoP).1 Systems and processes will be in place to ensure identified breaches of accreditation are appropriately managed and reported to ensure safe, high-quality care is maintained. Health practitioners will be afforded natural justice and the right to appeal decisions about their accreditation.

This procedure applies to the following categories of health practitioners:
i. Visiting medical officers
ii. Senior medical officers
iii. Sub-specialty fellows and registrars undertaking private practice/surgical assisting
iv. Visiting nursing, midwifery and allied health practitioners
v. Clinical visitors (including clinical researchers and medical observers/proctors)
vi. Other visiting practitioners (e.g. dental assistants, surgical assistants)

Note - This procedure does not apply to employed junior medical officers, employed nursing, midwifery and allied health practitioners, where they are working within their employed scope of practice as they are governed by an onboarding process overseen by Human Resources department.

1.2 Governing policy

The By-Laws (Mater Misericordiae Limited By-Laws for Accredited Practitioners 2021).

2. Procedure requirements

a. Initial accreditation is granted for a maximum 5-year period, with date for renewal based on period of tenure from approval date, not on a set date in the year.
b. In most instances, the relevant Regional Executive Director of Mater Health (or delegate e.g. Business Development team, Director of Clinical or Medical Services or Executive Officer) will firstly discuss organisational capability and need with the applicant and, if acceptable, will notify the Credentialing Office to invite the applicant to submit their application for further consideration.
c. A delegations register in this procedure provides a summary of who the CEO or Board delegates to perform duties in relation to the By-Laws.

2.1 Verification of credentials

The following documents will be reviewed to verify the applicant's credentials:
a. Curriculum Vitae (CV).
b. Qualifications which have been accepted and published for registration by the relevant national board (i.e. AHPRA) or professional body for those health practitioners not subject to AHPRA registration.
c. Submitted details of recognised postgraduate awards, fellowships and certificates that demonstrate successful completion of training from a relevant College, Association or training Institution (non-mandatory).
d. Evidence of relevant clinical activity, practice and experience in similar settings in which the SoP is being sought.
e. Evidence of ongoing professional development i.e. continuing professional education (CPE) or continuing professional development (CPD).
f. Evidence of Mater Health required learning (e.g. resuscitation, hand hygiene), including any evidence to support the SoP application.
g. Evidence of current and appropriate professional indemnity insurance, (including currency, limit of indemnity being a minimum of $20 million and the SoP covered).
h. Acknowledgement that the By-Laws have been read.
i. Evidence to validate the required '100-point ID' check.
j. Internet searches of the applicant.

2.2 Referee verification

a. The Credentialing Office will email a referee template to the nominated referees to obtain a maximum of two references for initial/amended SoP and one for renewals/mutual recognition.
b. References must be obtained from people who have observed and have first-hand experience of the applicant's clinical practice. At least one referee must be from their discipline/profession and at a minimum one referee will be either:
   i. the head of the speciality;
   ii. direct line manager (or equivalent) at the healthcare facility where the applicant most recently practiced or;
   iii. within or directly relevant to the field of practice in which the applicant will practice.

2.3 Internal review and verification

The Credentialing Office will email the completed application (including referee reports) to the relevant clinical director or delegate for review and verification of the applicant's suitability and also alignment to Mater Health's organisational capability and need. A peer review process will be undertaken to ensure review of the application by a practitioner of the same specialty.

2.4 Credentialing and Medical Advisory committees

a. The relevant Mater hospital Credentialing Committee will review all applications for accreditation for the relevant hospital, considering the Applicant's credentials, current SoP (if any), and the Hospital's organisational capability and need.
b. The Credentialing Committee will provide a recommendation of a Practitioner's application to the Credentialing Office advising if they are approved, declined, or if further documentation/information is required from the Practitioner.
c. The Credentialing Office will forward a monthly credentialing report listing all applicants who have been reviewed and endorsed through the internal review process to the Credentialing Committee, and then to the relevant regional Executive Director for sign-off.
d. The signed monthly report is then forwarded to the SEQ Medical Advisory Committee for noting.
e. All applications will be submitted to the Medical Advisory Committee/s for endorsement and recommendation made to the Regional Executive Director for approval and period of tenure or not approved and supporting reasons.

2.5 Successful applications

a. The Credentialing Office will prepare a letter to the applicant, appropriate to their accredited role, advising that their application for accreditation (including re-accreditation) has been successful outlining their practice rights, SoP, any special terms/conditions and term (of up to 5 years). This letter will include a statement that the health practitioner will be aware of their responsibility to:
   i. comply with Mater Health policies and procedures
   ii. submit written evidence annually or at times of any change to indemnity insurance
   iii. provide details of any changes / conditions imposed to their registration status
b. The Credentialing Office will:
   i. electronically store a copy of supporting documentation relating to each practitioner within the credentialing system
   ii. input/update the practitioner's details and accreditation status into the Health Provider Database (HPD) – for Mater SEQ only
   iii. input/update the credentialing system to move each approved application into the finalised application stage and update credentialing end date

2.6 Unsuccessful applications

a. Internal reviewers of applications will notify the Credentialing Office of applications not suitable to advance to the Credentialing Committee or Medical Advisory Committee for endorsement.
b. The Credentialing Office may seek additional information that is required to be disclosed by the applicant for further consideration of their application, if required.
c. Where an applicant is not to be progressed, the Credentialing Office will prepare a letter on behalf of the relevant Regional Executive Director, which will be forwarded to the applicant once signed. Details will be updated accordingly on the credentialing system to decline the lodged application.

2.7 Re-accreditation

a. Applications for re-accreditation at Mater Health are granted for a period of up to 5 years.
b. The Credentialing Office will invite accredited practitioners wishing to renew their clinical privileges at Mater Health, to submit their updated application at least 6 months before the expiry date of their accreditation.
c. Individual practitioners are responsible for submitting written evidence annually to the Credentialing Office regarding:
   i. on-going professional indemnity insurance
   ii. informing of any registration changes with the relevant health professional registration board (e.g. AHPRA)
   iii. all other relevant license or registrations relating to SoP including relevant regulatory requirements from colleges or professional bodies relevant to SoP (e.g. Royal Australasian College of Surgeons)
   iv. any changes that have occurred during the preceding period of practice. This also includes
d. Accredited medical practitioners will be requested to provide current evidence of their continuing professional development.

2.8 Accreditation for third party providers

a. The Board has endorsed that a modified credentialing process be adopted for selected third party providers based on their specific contractual arrangements. These entities may include:
    i. Radiology providers (Note – Interventional radiologists and practitioners with any SoP determined by the hospital executive will require full accreditation)
    ii. External pharmacy providers
    iii. Physiotherapy and other allied health providers
    iv. Pathology providers
b. This endorsement does not require practitioners employed by each entity to complete a full application for all types of accreditation at a Mater Health facility nor require internal review and endorsement.
c. For each group, a signed certification document for each practitioner outlining details of the new staff member (or staff member who is applying for re-accreditation), their medical indemnity cover and AHPRA registration will be provided by the third-party employer.
d. The Credentialing Office will issue a letter to the practitioner confirming accreditation pursuant to the agreement in place.
e. The practitioner's details will be uploaded into the credentialing system with their SoP and practice rights.
f. Where an applicant is not to be progressed, the Credentialing Office will prepare a letter on behalf of the relevant Regional Executive Director, which will be forwarded to the applicant once signed. Details will be updated on the credentialing system to decline the lodged application.

2.9 Surgical assistants

a. Surgical assistants are only required to complete a short application where they will practice under the direct supervision of the Surgeon they practice with, and to provide their CV, 100 points of ID, professional medical indemnity insurance and confirmation they are registered with AHPRA. If the applicant is undertaking an AHPRA supervised practice plan, a copy of this documentation is required. Dental assistants without AHPRA registration will be considered on a case by case basis, however, must demonstrate evidence that they hold a base qualification of at least a Certificate III.
b. The delegate of the Regional Executive Director may require some applicants to undertake the full accreditation application process where they are assessed as higher risk e.g. undertaking periods of unsupervised practice by Surgeon in complex procedures such as cardio-thoracic surgery or other complex surgical procedures.
c. These practitioners will only require endorsement by the relevant regional Executive Director or delegate.
d. Applications will be forwarded to the Credentialing Committee and Medical Advisory Committee for noting and a standard recommendation made to the Regional Executive Director for approval.
e. The practitioner's details, SoP and practice rights will be uploaded into the credentialing system.
f. Successful applications for surgical assisting rights at Mater Health will receive accreditation for a period of up to 5 years.

2.10 Accreditation for Stryker Mako® Orthopaedic surgical system (Townsville)

a. Staff working with the Stryker Mako® orthopaedic surgical system will have successfully completed a comprehensive training program and associated practical assessments.
b. The training program will be facilitated by either the Device Technology Representative, or the Mater Private Hospital Townsville Robotic Coordinator.
c. Prerequisites required to apply for accreditation for the Stryker Mako® orthopaedic surgical system are:
    I. The medical practitioner must be currently credentialed within their surgical specialty 'Orthopaedics' at Mater Private Hospital Townsville;
    II. Has current arthroplasty surgical skills: Total Hip Replacement, Total Knee Replacement, Partial Knee Replacement;
    III. Has experience in using surgical navigation systems for joint replacement surgery;
    IV. Has completed the Stryker Mako® Robot one-day training program; and has certificated proof of attendance and completion of the one-day training program and online training modules for each procedure (total knee replacement, partial knee replacement, and total hip replacement) for each applicant.
d. The medical practitioner will be required to apply for a change in their Scope of Practice to include Mako® robotic-assisted surgical procedures for their specialty.
e. The application will be considered by the Credentialing Committee, and a recommendation will be made to the Medical Advisory Committee and the Executive Officer for acceptance of the application.

f. The VMO may elect to seek proctoring support. Note – the proctor must apply for accredited medical practitioner AND must provide evidence of their qualifications and a minimum number of 50 cases of that application.
g. The medical practitioner may be given exemption or full accreditation at the discretion of the Executive Officer if they have already completed the Stryker Mako® one-day training program and/or have previous training and experience in Mako Orthopaedic Robotic Assisted Surgery. Documented evidence of completion of the training program and of previously independently performed cases is required.
h. All newly accredited medical practitioners will have their first 10 cases reviewed. A full review of these cases will be undertaken by the Chair of the Orthopaedic Specialty Group in consultation with the Executive Officer.
i. Accredited medical practitioners who wish to proctor at Mater Private Hospital Townsville must apply to the Executive Officer in consultation with the Chair of the Orthopaedic Specialty Group.
j. Monitoring of patient outcomes will occur via monthly Morbidity and Mortality reviews and Specialty Groups.

2.11 Temporary accreditation

a. Applications for temporary accreditation at Mater Health will be considered in exceptional circumstances in accordance with the By-laws and after consideration by the delegate of the Regional Executive Director.
b. The Medical Advisory Committee and/or Credentialing Committee will be responsible for making recommendations to the Regional Executive Director following review of the applications and can refuse an application if concerns are raised.
c. Temporary accreditation may be approved by the delegate of the Regional Executive Director on an exception basis only, and for a one-off period of three months. Any further requests for extension of temporary accreditation must be made to the Regional Executive Director prior to end of temporary accreditation period expiring with reasons for request.
d. Temporary accreditation should not be considered to be a routine process used to bring practitioners into the system, the application process for most practitioners should be undertaken through the standard application processes. Auditing and reporting on proportion of temporary accreditation granted at each hospital will be monitored and reported through clinical governance processes within each hospital and across Mater Health.
e. Seconded registrars from a Queensland Health facility who are providing on-call Mater Health services from another hospital require temporary accreditation or a letter confirming their role and that Queensland Health provides professional indemnity.

2.11.1 Temporary accreditation during business hours

The Credentialing Office will:
a. receive notification from the relevant clinical area of a health practitioner wanting to provide patient care who is not already accredited at Mater Health, this must have verbal or written approval from the delegate of the Regional Executive Director;
b. confirm the identity of the health practitioner through relevant verification documents (e.g. current driver's licence with photograph, staff ID badge), and checking current registration status via AHPRA or other regulation body website. Specialty registration will need to match the SoP for which the Health Practitioner will be providing patient care at Mater Health;
c. confirm the health practitioner holds current indemnity insurance (including currency, limit of indemnity being a minimum of $20 million and the SoP covered);
d. contact the relevant clinical speciality lead/delegate for approval of emergency accreditation;
e. advise the practitioner of the emergency accreditation being approved or declined;
f. update the credentialing system with temporary accreditation.

2.11.2 Temporary accreditation after hours

The after-hours manager (AHM) will:
a. be notified by the relevant clinical area if a health practitioner presenting to provide patient care is not accredited at Mater Health, this must have verbal or written approval from the delegate of the Regional Executive Director;
b. confirm the identity of the health practitioner through relevant verification documents (e.g. current driver's licence with photograph, staff ID badge), and checking current registration status via the AHPRA website. Specialty registration will need to match the SoP for which the health practitioner will be providing relevant patient care at Mater Health;
c. confirm the health practitioner holds current indemnity insurance (including currency, limit of indemnity being a minimum of $20 million and the SoP covered);

d. contact the relevant regional Executive Director of Mater Health or delegate (i.e. on-call executive) for approval of emergency accreditation;
e. inform the credentialing office via email of the emergency accreditation including the following details:
    i. Name of practitioner
    ii. Name of patient
    iii. Reason for admission, including specialty services to be provided
    iv. Mater health facility
    v. Name of relevant regional Executive Director or delegate who approved the emergency accreditation

The Credentialing Office will update the credentialing system with temporary accreditation.

2.12 Variation to scope of clinical practice (SoP)

a. The health practitioner will be required to complete a Request for Amendment of Accreditation or SoP Application and provide relevant supporting documentation (i.e. evidence of additional qualifications and/or training to support amended SoP being applied).
b. Variations to SoP will also arise when there is a request for the introduction of a new clinical service, procedure or other intervention.
c. All applications to variation to SoP must be considered and approved by the Regional Executive Director.
d. If approved by the Regional Executive Director, the credentialing office will issue a letter to the practitioner confirming the approval/non-approval to the variation of SoP accreditation.

2.13 Mutual recognition

2.13.1 Internally recognised health practitioners (Mater Health employees)

a. Where an accredited health practitioner that holds existing accreditation at a Mater Health facility and requires mutual accreditation for the purposes of providing services, a process of mutual recognition for accreditation is used.
b. The health practitioner will have the same SoP recognised as credentialed in the other Mater facility/facilities.
c. SoP must align with the clinical capability and licensing of the Mater facility to which accreditation is being sought at.
d. The maximum period of accreditation that can be recommended will be determined by the re-accreditation date of the practitioner held at the other Mater Health facilities.
e. The accredited health practitioner will be provided with access within the credentialing system by the Credentialing Officers, to complete a Mutual Recognition Application, with declarations and authorisations.
f. The Credentialing Office will process the application and submit it to the relevant Regional Executive Director or delegate to confirm organisational capability and need, before submitting the application to the next Medical Advisory and/or Credentialing Committee meeting for consideration.
g. The relevant Medical Advisory and/or Credentialing Committee will consider the accreditation application based on mutual recognition of the credentialing processes undertaken at the organisation, where the health practitioner is primarily employed or has existing accreditation. ‘
h. The relevant committee will make a recommendation for accreditation, including SoP to the Regional Executive Director for the region for approval. Where the mutual recognition crosses SEQ and CNQ region, then both Regional Executive Directors must complete approval process.
i. The accreditation period will be no longer than the period of time until the health practitioner is due for re-accreditation at their primary accredited facility.
j. The Credentialing Office will update the credentialing system, where a notification will be automatically forwarded to relevant linked systems.
k. A notification letter will be forwarded to the accredited health practitioner confirming their SoP.

2.13.2 Externally recognised health practitioners (Queensland Health employees)

a. If a health practitioner is employed for at least 0.5 FTE at a Queensland Health facility, then a process of mutual recognition for accreditation will be utilised, if approved by the Regional Executive Director.
a. The health practitioner may only have the same SoP recognised as credentialed in the Queensland Health facility that is being used for mutual recognition.

b. SoP must also align with the clinical capability and licensing of the Mater facility to which accreditation is being sought.
c. The maximum period of accreditation will be determined by the accreditation period appointed at the Queensland Health facility.
d. The health practitioner must complete a Mutual Recognition application for Mater Health accreditation (provided by the Credentialing Officers).
e. Where a health practitioner's existing accreditation is with a Queensland Health facility, the practitioner must provide authorisation for the credentialing office to obtain:
    i. a record of their existing accreditation at that facility
    ii. a copy of the Queensland Health accreditation application form, which includes the health practitioner's CV, photo identification and references
    iii. a copy of the Queensland Health facility accreditation letter which outlines the health practitioner's SoP and the term of their accreditation at this facility.

2.14 Clinical visitors, observers, scribes, supervised clinical practice, medical proctor, clinical researcher

a. All clinical visitors, observers, scribes, supervised clinical practice, medical proctor or clinical researcher will be considered for approval by the Regional Executive Director or delegate.
b. All clinical visitors will always be directly supervised by an authorised Mater Health practitioner.
c. Clinical observers will not participate directly in the care of a patient at Mater Health.
d. Scribes employed by an accredited practitioner do not require accreditation under the By-Laws, however, the accredited practitioner who employs them will ensure the following in accordance with the By-laws:
    i. that patient records contain complete and adequate information relating to care and treatment;
    ii. that full, accurate, legible and contemporaneous records are maintained at all times including that entries are dated, time and signed and are sufficient to allow any person involved in care, at any point in time, to understand the instructions, orders and treatment plan.
e. Clinical visitors participating in supervised clinical practice must be registered with AHPRA where applicable and hold appropriate professional indemnity insurance.
f. The nominated supervisor will ensure the patient consent processes have been undertaken for all clinical visitors, medical proctors/observers or clinical researchers.
g. The clinical visitor will obtain a visitor Mater ID badge from the Security Office which will be returned at the completion of the visit.
h. The relevant clinical areas will be notified of the clinical visitor, medical observer/proctor or clinical researcher's presence, and role in that area.
i. Clinical Researchers attending Mater must have approval from the Mater Health Human Research Ethics Committee (HREC) to conduct research study, and also approval from the Information Private Office if access is required to Mater patient information/data.
j. Consideration of privacy, confidentiality and consent of patients involved in care of any of the roles in this category must be considered by the Regional Executive Director in their decision whether to grant approval and duration or conditions of approval.

2.15 Routine review of accredited practitioner after initial 12 months

a. All accredited practitioners will undergo formal or informal review routinely on or around 12-month anniversary from initial accreditation tenure date. This may include but is not limited to: review of activity and clinical outcomes, feedback from multidisciplinary healthcare teams, review of incidents and complaints, comparison of activity with approved SoP or any other relevant information.
b. A summary of the 12-month review will be provided in the accredited practitioner's cGov file and a report provided quarterly to each Regional Executive Director and hospital/Mater Health governance committees to monitor compliance and outcomes.

2.16 Concerns about an accredited practitioner

a. Concerns about an accredited practitioner can arise from a situation, behaviour, event, incident or complaint, or can be found through established clinical governance processes that aim to identify contributory factors to variation in processes, outcomes or systems.
b. Mater Health has a number of systems and processes in place to proactively identify these types of concerns however it is recognised that variation in performance (particularly variation that is considered

to be outside that of peer clinical skill and competence) and the ability to recognise clear underperformance can often be difficult to identify.

c. Concerns raised about an accredited practitioner may require additional / independent clinical expertise to make judgements about identified concerns with such matters being managed in line with the By-Laws.
d. All matters where concerns resulted in proposed conditions, undertakings, suspension, or termination must be escalated by the Regional Executive Director to the Executive Director Mater Health and CEO for discussion and approval.

2.17 Documenting concerns and management of accredited practitioners

a. Mater people who develop a concern about an accredited practitioner through internal systems are encouraged to escalate and share it with the relevant delegate of the Regional Executive Director.
b. Concerns that arise through external sources will be shared directly with the relevant delegate of the Regional Executive Director who will decide if the issue warrants notation against the accredited practitioner's profile in the credentialing system and what ensuing action is required.
c. When a concern is to be formally recorded, the relevant Regional Executive Director or their delegate will provide the Credentialing Office with details to register against the accredited practitioner's credentialing file.
d. Summary notations will be made in the credentialing system to record key information about the concern and the proposed management.
e. Regular reviews will be undertaken using the credentialing system to identify the list of accredited practitioners with active concerns and the progress with actions to ensure ongoing management and follow-up occurs.

2.18 Auditing and compliance

a. Scheduled auditing of a random sample of accredited practitioners to identify the following will be regularly undertaken:
    i. Practising within approved SoP
    ii. Procedures performed align with Mater's private licensing arrangements / Clinical Services Capability Framework
    iii. Any unwanted clinical outcome variation is identified
    iv. Numbers of procedures being performed align with Mater Health thresholds.
b. The program of auditing will comply with the credentialing requirements outlined within the By-Laws, to ensure that the key requirements of accredited practitioners are continuously met and align with the requirements for accreditation and jurisdictional standards, and legislation. There are two components to the auditing process for credentialing, firstly the administrative credentialing component audited against credentialing application processes and secondly, the clinical practice component audited against terms and conditions of the By-Laws with clinical outcomes for accredited practitioners on a risk-based sampling process.
c. The e-credentialing system provides a dashboard of key metrics required for the administrative credentialing component of the audits they will be extracted on business day 3 of each month by the Credentialing Officers for each hospital quality or executive team to provide exception commentary on defined KPI's and reported to Executive Director, Mater Health and key governance committees on business day 7 of each month.
d. An annual audit schedule and audit tool will be created by Credentialing Officers and Quality and Safety Manager Mater Health, assigning auditors to ensure independence of the audited activity, and to undertake specific tasks appropriate to the auditor's knowledge and skills.
e. Then annual audit schedule and audit tool will be approved by the Mater Health Credentialing Governance Committee and tabled at Mater Health Clinical Systems Committee as part of annual work plan for the committees. The audit schedule will be made available for all hospital and Mater Health leaders involved in credentialing processes.
f. Audit scope will include a percentage or 15 health practitioners (whichever is the lessor) each month across Mater Health, with hospitals rotated for auditing across the year but at least quarterly for each hospital.
g. For administrative audit component, a sub-set of files from each stage of the credentialing process in the e-credentialing system will be sampled.
h. For clinical practice audit component, a risk-based approach in consultation with the hospital executive will determine accredited practitioners to be included in the audit scope. The audit will include chart review to determine health practitioner service provision to patients aligned to terms and conditions of the

By-Laws, review of accredited practitioner activity in the patient management system, review of any relevant incidents/complaints or clinical indicator data, and any other related areas to determine confirmation of scope of clinical practice and clinical outcomes of practice.

i. The auditor will review the audit results and identify any areas of noting and, prepare an audit report documenting identified opportunities for improvement, areas for concern or non-conformances.
j. The auditor will provide audit results to the hospital executive and Regional Executive Director and discuss any concerns, provide responses to questions/clarification.
k. The hospital executive / Regional Executive Director will be accountable for reviewing the audit results, documenting evidence of any corrective actions taken within the e-credentialing system and maintaining status updates. They will advise the Clinical Governance team if there are ongoing audit requirements to monitor concerns or outcomes and agree on processes going forward.
l. A de-identified high-level summary of audit process, scope and results will be provided by the Clinical Governance Team to the Executive Director Mater Health quarterly and relevant governance committees.

2.19 Reporting

a. Scheduled reporting on accredited practitioners will be provided to the Regional Executive Director, hospital governance committees, Mater Health Executive Director/CEO and Clinical and Business Systems (Board) Committee.
b. These reports will include the following information:
    i. Number of new health practitioners accredited, including amendment of SoP and Mutual Recognition
    ii. Number of re-credentialed practitioners
    iii. Number of accredited practitioners that have been identified as carrying conditions / restrictions to their practice
    iv. Overview of audit results, KPI's and corrective actions

2.20 Escalation

The following matters will be escalated to the Director of Clinical Governance Mater Health or their delegate for further consideration:

a. Conditions, restrictions and anomalies noted relating to a practitioners AHPRA registration status.
b. Practitioners failing to provide required information relating to their application and/or accreditation at Mater Health.
c. Professional indemnity requests and situations.
d. Matters considered to be falling outside an accepted SoP.

2.21 Credentialing of allied health, nursing, midwifery and pharmacy professionals

a. Allied health, nursing, midwifery and pharmacy professionals do not need to apply for accreditation if they are:
    i. employed by MH and have therefore been assessed as possessing the clinical skills to undertake their role and have ongoing supervisions
    ii. undertaking non-clinical roles
    iii. students under formal supervision arrangements in accordance with training deeds of agreement
    iv. providing services independently of Mater Health whereby the patient is not a Mater patient e.g. private outpatient services
b. All other allied health, nursing, midwifery and pharmacy professionals, unless covered by a third-party agreement, will be required to apply for accreditation through the Credentialing Office.
c. Applications will be considered in accordance with this procedure.
d. The credentialing committee will at a minimum include the delegate of the Regional Executive, and the most senior Mater clinician of that discipline. Where Mater does not have a Mater employee of the appropriate discipline, external representatives will be engaged. Members of the credentialing panel will be asked to declare any conflicts of interest (e.g. personal relationship with the applicant).
e. The credentialing panel will make a recommendation to the relevant delegate of the Regional Executive Director regarding credentialing of the applicant, based on their qualifications, training and experience against the requested scope of clinical practice, referee reports and the organisational need for the service for the relevant facility.
f. The period of accreditation will be up to five years, as determined by the Regional Executive Director, temporary accreditation may be approved upon consideration under exceptional circumstances.

g. The applicant will be notified in writing of the outcome of their application including approval or otherwise, details of the accreditation category, type and scope of practice.

2.22 Delegations Register

Unless stated otherwise in the specific condition of the delegation, the delegation to approve a function includes the power to approve, amend or refuse approval as the delegate thinks necessary or expedient to the proper exercise or discharge of the power. Decisions by the delegate are to be in accordance with specific conditions of the delegation and processes stated in relevant legislation, Mater policies, procedures and By-Laws.
The delegations register reflects the roles and responsibilities conferred by the Mater Health By-Laws for accreditation, pursuant to By-Law 3.2 Delegation and Delegations Register.

By-Law		In this By-Law, the "CEO or Delegate" means:
5.5 Standard of Conduct and Behaviour	(d) An accredited Practitioner is expected to promptly report to the CEO or delegate a breach or potential breach by another Accredited Practitioner of any of the matters set out in (a) or (b) above.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
5.6 Notifications	(a) Accredited Practitioners must immediately advise the CEO or delegate and follow up with written confirmation within 2 days…	Director of Medical Services (SEQ) or Executive Officer (CNQ)
5.7 Obligations to Disclose	(a) The Accredited Practitioner must keep the CEO or delegate continuously informed of every fact and circumstances which has, or will likely have, a material bearing upon…	Director of Medical Services (SEQ) or Executive Officer (CNQ)
5.8 Representations and Media	(a) Unless an Accredited Practitioner has the prior consent of the CEO or delegate or is authorised by virtue of his/her employment, an Accredited Practitioner may not use the Facility's name…letterhead or in any way suggested that the Accredited Practitioner represents these entities.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
	(c)Accredited Practitioner must obtain the CEO or delegate's prior written consent before interaction with the media regarding any matter involving or relating to Mater Health or the Facility, A Patient of the Accredited Practitioner admitted to or previously admitted to the Facility, or any matter involving or related to Mater Health or the facility.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
	(e) If there is any instance of non-compliance with any of the matters set out above, in addition to this constituting a breach of the By-Laws, the Accredited Practitioner is required to follow the directions of the CEO or delegate in managing the consequence of non-compliance, including a retraction or agreed public statement.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
5.9 Confidentiality	(g) If a breach of any of the confidentiality obligations set out above occurs, including through inadvertence or a third-party cyber security breach, then the Accredited Practitioner must immediately notify the CEO or delegate and actively assist to resolve the breach.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
6.1 Clinical Practice and Continuous Improvement	(f) failure to comply with a reasonable request to participate in patient care and service review processes, as set out in this By-Law, will at the discretion of the CEO or delegate constitute ad	Director of Medical Services (SEQ) or Executive Officer (CNQ)

By-Law		In this By-Law, the "CEO or Delegate" means:
	breach of the terms and conditions of Accreditation.	
6.5 New Clinical Service, Procedure, Therapeutic Medicine, therapeutic Good, Medical Device, Technology or other Intervention	Accredited Practitioners proposing to introduce, provide or use a New Clinical Service, Procedure, Therapeutic Medicine, Therapeutic Good, Medical Device, Technology or other Intervention will provide the CEO or delegate with supportive evidence to the satisfaction of the CEO or delegate in keeping with the agreed governing policy and procedures of Mater Health and the Facility, in accordance with the timeframe set out in the policy and procedure.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
	Following consideration of the reported outcomes and benefits referred to in (h) above, the CEO or delegate may withdraw approval for the continuation of the New Clinical Service, Procedure, Therapeutic Medicine, Therapeutic Good, Medical Device, Technology or other Intervention, or may impose restrictions, with there being no right of appeal from this decision.	Director of Medical Services (SEQ) or Executive Officer (CNQ) escalate to Regional Executive Director for decision and notification to Executive Director Mater Health and CEO Mater.
6.6 Admission, Availability, Resources, Communication and Discharge	(a) Accredited Practitioners will admit or consult patients at the Facility on a regular basis within any twelve-month period or as reasonably determined by the CEO or Delegate in relation to a specific clinical specialty.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
	(q) Accredited Practitioners will ensure that any changes to contact details are notified promptly to the CEO or delegate and ensure that this is recorded in any other document prescribed by the Facility for documenting and communicating such changes.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
6.11 Research	(a) The Facility approves, in principle, the conduct of research (including a clinical trial) in the Facility. However, no research will be undertaken without the prior approval of the CEO or delegate and the HREC (where required), following submitted application by the Accredited Practitioner in the required form and with all required information.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
6.12 Utilisation of Accreditation	Accredited Practitioners will be advised upon Accreditation or Re-Accreditation, or at any other times as determined by the CEO or delegate, of the expectations in relation to exercising Accreditation and utilisation of the Facility.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
7.1 Eligibility for Accreditation as a Medical Practitioner	(a) Accreditation as a Medical Practitioner will only be granted if the Applicant demonstrates to the satisfaction of the CEO or delegate adequate Credentials, meets requirements of Organisational Capability and Organisational Need, otherwise satisfies the requirements of the By-Laws, agrees to comply with and accept all terms, conditions and processes set out in the By-Laws (including as amended from time to time) and provides written acknowledgment or electronic confirmation of such agreement.	Director of Medical Services (SEQ) or Executive Officer (CNQ) recommendation to Regional Executive Director for approval
7.3 Responsibility and Basis for	(a) The CEO or delegate will determine the outcome of applications for Accreditation as	Director of Medical Services (SEQ) or Executive Officer

By-Law		In this By-Law, the "CEO or Delegate" means:
Accreditation and Granting of Scope of Practice	Medical Practitioners and the defined Scope of Practice.	(CNQ) recommendation to Regional Executive Director for approval
7.3 Credentialing and Accreditation	(c) Credentialing processes will be facilitated by appropriately appointed credentialing committees which will act as committees and comply with any relevant requirements or standards applicable to the facility.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
	(d) the primary role of the credentialing committee will be to review the credentialing requirements set out in these By-Laws, along with any associated approved policies and procedures, and make recommendations to the CEO or delegate about the suitability of the Applicant to receive Accreditation and sought after Scope of Practice.	Regional Executive Director
	(e)with the approval of the CEO or delegate, the Medical Advisory Committee membership may constitute the Medical Credentialing Committee and may establish Medical Specialist Credentialing Panels to assist in meeting their obligations.	Regional Executive Director
	(f) Nursing and Midwifery and Allied Health Credentialing Committees will be constituted as directed by the CEO or delegate.	Regional Executive Director
	(i) Prior to proceeding with an application or at any time during the Credentialing process, the CEO or delegate may request the Applicant to attend an interview (along with other representatives of Mater Health or the facility).	Director of Medical Services (SEQ) or Executive Officer (CNQ)
	(j) as determined by the CEO or delegate, any refusal or failure to fully respond to the requests made in (i) above may result in rejection of the application.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
7.5 Medical Advisory Committees	(a) The CEO or delegate will establish Medical Advisory Committees to support each facility.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
	(b) The MAC members, including the chairperson, will be Accredited Practitioners (or at least a majority of Accredited Practitioners) and appointed for periods as determined by the CEO or delegate.	Director of Medical Services (SEQ) or Executive Officer (CNQ) recommend to the Regional Executive Director for approval
8.1 Applications for Initial Accreditation, Re-Accreditation and Mutual Recognition as Medical Practitioners	(b)under exceptional circumstances due to urgent patient need, Temporary Accreditation may be approved by the CEO or delegate pending final consideration of the application.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
	(c)The CEO or delegate will consider applications or Initial Accreditation, Re-Accreditation and Mutual Recognition in order to undertake his/her responsibility of Credentialing in accordance with these By-Laws and any associated policy and procedures.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
	(d) The CEO or delegate will ensure applications are complete and requests for further information complied with, and upon being satisfied will refer applications, together with notes and feedback to the MAC and/or Credentialing Committee for consideration.	Director of Medical Services (SEQ) or Executive Officer (CNQ)

	By-Law	In this By-Law, the "CEO or Delegate" means:
	(h) The MAC and/or Credentialing Committee will make recommendations to the CEO or delegate as to whether the application should be approved and if so, on what terms, including the Accreditation Category, Accreditation Type and Scope of Practice to be granted.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
	(k) Following receipt of the recommendation from the MAC and/or Credentialing Committee, the CEO or delegate will decide whether the application should be rejected or approved and if the application is approved, the Scope of Practice, period of accreditation and whether any additional terms or conditions will apply.	Regional Executive Director
	(l) In considering applications, the CEO or delegate will give due consideration to any recommendations or other information relevant to the application as determined by the CEO or delegate, and may make any additional enquiries as the CEO or delegate determines appropriate, with the final decision that of the CEO or delegate.	Regional Executive Director
8.2 Consideration of Applications for Initial Accreditation by the CEO or delegate	a) The CEO or delegate will consider applications for initial accreditation, following receipt of a recommendation from the MAC and/or Credentialing Committee, to decide whether applications should be rejected or approved and if approved the scope of practice, accreditation period and whether any additional terms and conditions will apply.	Director of Medical Services (SEQ) or Executive Officer (CNQ) followed by Regional Executive Director
	c)The CEO or delegate may defer consideration of an application in order to obtain further information from other stakeholders in executive operational roles, the MAC and /or Credentialing Committee, the applicant or any other person or organisation.	Director of Medical Services (SEQ) or Executive Officer (CNQ) followed by Regional Executive Director
	d) If the CEO or delegate requires further information from the Medical Practitioner before making a determination then they will notify the Medical Practitioner.	Director of Medical Services (SEQ) or Executive Officer (CNQ) followed by Regional Executive Director
	e) In the event that the information or documents requested by the CEO or delegate is not supplied in the time set out in the notification, the CEO or delegate may, at their discretion reject the application or proceed to consider the application without such additional information.	Director of Medical Services (SEQ) or Executive Officer (CNQ) followed by Regional Executive Director
	(f) The CEO or delegate will forward a notification to the Medical Practitioner advising them whether the application has been approved or rejected.	Regional Executive Director
	g) The CEO or delegate will ensure that information relating to the Accreditation Category, Accreditation Type and Scope of Practice is accessible to those providing/managing clinical services within the facility.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
8.3 Initial Accreditation Tenure	(a) Initial Accreditation as a Medical Practitioner at the facility will be for a period of up to a maximum of 5 years, as determined by the CEO or delegate.	Regional Executive Director
8.4 Consideration of Applications for RE-	c)If an Accredited Practitioner in the 12 months prior to receipt by the Facility of the application has not admitted or treated a patient at the facility, the	Director of Medical Services (SEQ) or Executive Officer

By-Law		In this By-Law, the "CEO or Delegate" means:
Accreditation by the CEO or delegate	CEO or delegate may elect to notify the Accredited Practitioner that the application for Re-Accreditation has not been accepted due to the failure to exercise Accreditation sufficiently and any future application will need to be in accordance with the process for Initial Accreditation.	(CNQ) followed by Regional Executive Director
	(d) the CEO or delegate, MAC and / or Credentialing Committee will deal with applications for Re-Accreditation in the same manner in which they are required to deal with applications for Initial Accreditation.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
8.5 Re-Accreditation Tenure	a) Re-Accreditation as a Medical Practitioner at the facility will be for a period of up to a maximum of 5 years, as determined by the CEO or delegate.	Regional Executive Director
8.6 Mutual Recognition	a) In the complete discretion of the CEO or delegate, a process for Mutual Recognition may be established involved the local HHS, that allows for the Medical Practitioners from the public sector attending the facility to treat public patients or Accreditation between MH facilities where the applicant already holds accreditation at one MH facility.	Regional Executive Director
	c) If an applicant holds accreditation at one facility and seeks accreditation at another facility, the CEO or delegate will determine whether the application will be treated as an application for initial accreditation or a more streamlined process established to rely on information supplied by the facility at which the accredited practitioner holds accreditation.	Director of Medical Services (SEQ) or Executive Officer (CNQ) followed by Regional Executive Director
8.7 Surgical Assistants, Employed Junior Medical Practitioners or Fellowships	a) In the complete discretion of the CEO or delegate, more streamlined process may be established for the Accreditation Category of Surgical Assistant-Medical Practitioner or with respect to an employed Junior Medical Practitioner or Fellowship.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
8.8 Third Party Providers	a) If certain services are delivered by third party providers, such as medical imaging or pathology, the CEO or delegate may require Medical Practitioners or other categories of health practitioner delivering the servicers on behalf of the third party provider to firstly be granted Accreditation pursuant to these By-Laws. Alternatively, the CEO or delegate may require the third party provider to undertake its own Accreditation process and to ensure that the Credentials, professional registration and professional indemnity insurance are strictly verified and then to provide confirmation that this has occurred and/or to provide suitable evidence to the CEO or delegate.	Director of Medical Services (SEQ) or Executive Officer (CNQ) followed by Regional Executive Director
	b) In the event a third- party provider undertakes its own Accreditation process, Scope of Practice and access to the Facility by a particular Medical Practitioner or other category of health practitioner at all times will be decided by and remains the responsibility of the CEO or delegate.	Director of Medical Services (SEQ) or Executive Officer (CNQ) followed by Regional Executive Director

By-Law		In this By-Law, the "CEO or Delegate" means:
9.1 Temporary Accreditation	Medical Practitioners may be granted Temporary Accreditation and Scope of Practice on terms and conditions considered appropriate by the CEO or delegate;	Director of Medical Services (SEQ) or Executive Officer (CNQ)
	c)Temporary Accreditation processes may, at the election of the CEO or delegate, be utilised for a Medical Proctor (also known as a Medical Observer). The process will be modified to suit the specific circumstances and will be confined to a particular attendance rather than a period of time.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
	e) Temporary Accreditation may be terminated by the CEO or delegate for failure by the Medical Practitioner to comply with the requirements of the By-Laws or failure to comply with Temporary Accreditation requirements.	Director of Medical Services (SEQ) or Executive Officer (CNQ) followed by Regional Executive Director and notification to Executive Director Mater Health and CEO Mater
	f) Temporary Accreditation will automatically cease upon a determination of the Medical Practitioner's application for Accreditation (if an application for Accreditation has been made) or at such other time as the CEO or delegate decides.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
	g) The period of Temporary Accreditation shall be determined by the CEO or delegate. If the period of Temporary Accreditation is for a period of time rather than an episode of care or specific attendance, this will be for an initial period of no longer than three (3) months and then be limited to one period of extension of three (3) months. If in exceptional circumstances a further period of time may be required beyond that set out in this By-Law, a specific request must be made to the CEO or delegate and the exceptional circumstances set out in order for consideration to be given to the request	Director of Medical Services (SEQ) or Executive Officer (CNQ) for up to three-month period. For any period beyond three months – Regional Executive Director
	i) In circumstances of an emergency, Temporary Accreditation may be considered by the CEO and/ or delegate for short notice requests, subject to professional body registration and identity verification, to ensure continuity and safety of care for Patients and/or to meet Organisational Need.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
	k) Verification and information gathering processes set out in this By-Law will be undertaken by the CEO or delegate and will be fully documented.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
	l) If Temporary Accreditation was granted based upon an emergency request, it will be approved for a limited period as identified by the CEO or delegate, for the safety of patients involved, and will automatically terminate at the expiry of that period or as otherwise determined by the CEO or delegate.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
	n) The CEO (if undertaken by a delegate), Medical Advisory Committee and /or Credentialing Committee will be informed of all Temporary Accreditation granted.	Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director

By-Law		In this By-Law, the "CEO or Delegate" means:
9.2 Locum Cover	Locums must be approved for Locum Cover by the CEO or delegate before they are permitted to arrange the admission of and/or to treat Patients on behalf of Medical Practitioners.	Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director
11.1 Review of Accreditation and /or Scope of Practice	a) The CEO or delegate may at any time initiate a review of an Accredited Practitioner's Accreditation and/or Scope of Practice where concerns have been identified or allegations made about any of the following in relation to the Medical Practitioner… The Board may request that the CEO or delegate undertake a review pursuant to this By-Law, and if this occurs, then the CEO or delegate must undertake the review. A review may be requested by any other person or organisation, including external to the Facility, however the commencement of a review remains within the sole discretion of the Board or the CEO (other than if the Board has requested that the CEO or delegate undertake a review, then the CEO or delegate must undertake the review).	Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director followed by report to Executive Director Mater Health and CEO Mater
	c) The CEO or delegate will determine whether the process to be adopted is an: Internal Review; or External Review.	Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director followed by report to Executive Director Mater Health and CEO Mater
	e) Prior to determining whether an Internal Review or External Review will be conducted, the CEO or delegate may in their absolute discretion seek further information from Hospital Executive and /or may in their absolute discretion meet with the Accredited Practitioner (the Accredited Practitioner may choose to bring along a support person), along with any other persons the CEO or delegate considers appropriate. In advance of or at the meeting the CEO or delegate will advise of the concern or allegation raised, and invite a preliminary response from the Medical Practitioner (in writing or orally, as determined by the CEO or delegate), which response may be given at and/or following the meeting. Thereafter, the CEO or delegate will make a determination whether a review will proceed, and if so, the type of review.	Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director followed by report to Executive Director Mater Health and CEO Mater
	f) The Medical Practitioner who is the subject of a review, whether an Internal Review or External Review: must cooperate fully with the reviewers, including providing information reasonably required to inform the reviewers, failing which the CEO or delegate may make a determination to immediately proceed to suspension or termination of Accreditation.	Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director followed by report to Executive Director Mater Health and CEO Mater
	g) Given that the review process, the terms of reference, access to information and reviewers are within the complete discretion and determination of the CEO or delegate, any deviations from the established process will not result in a flawed process and appropriate actions and response to	Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director followed by report to Executive Director Mater Health and CEO Mater

By-Law		In this By-Law, the "CEO or Delegate" means:
	deviations will be as determined by the CEO or delegate.	
	i) The CEO or delegate may, in their complete discretion, make a determination regarding interim suspension of Accreditation or placing conditions on Accreditation pending the outcome of the review. There is no right of appeal available against a decision to impose an interim suspension or conditions.	Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director followed by report to Executive Director Mater Health and CEO Mater
	j) Circumstances may arise where the CEO or delegate determines that, in addition to undertaking a review, they are mandated by legislation or believe it is in the public's (including patients at other facilities) or patient's interest to notify the Office of Health Ombudsman, AHPRA and/or other accrediting professional organisations of the details of the concerns that have been raised regarding the Medical Practitioner.	Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director followed by report to Executive Director Mater Health and CEO Mater
	The CEO or delegate in their absolute discretion, may decide that as an alternative to conducting an Internal Review or External Review the concerns that have been raised regarding the Medical Practitioner should immediately be notified to the Office of Health Ombudsman or AHPRA for those organisations to take the requisite action. Following the outcome of any such action, the CEO may, at their absolute discretion, elect to take any further action they consider appropriate under these By-Laws.	Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director followed by report to Executive Director Mater Health and CEO Mater

By-Law		In this By-Law, the "CEO or Delegate" means:
11.2 Internal Review of Accreditation and / or Scope of Practice	a) The CEO or delegate will draft the terms of reference of the Internal Review, and may seek assistance from the Medical Advisory Committee and/or Credentialing Committee or co-opted Medical Practitioners or personnel from within the Facility who bring specific expertise to the Internal Review, as determined by the CEO or delegate. b) The terms of reference, process, access to information and reviewer(s) will be as determined by the CEO or delegate. The CEO or delegate will notify the Medical Practitioner in writing of the review, the terms of reference, process, material to be provided and reviewer(s).	Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director followed by report to Executive Director Mater Health and CEO Mater Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director followed by report to Executive Director Mater Health and CEO Mater
11.3 External Review of Accreditation and / or Scope of Practice	Entire section	Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director followed by report to Executive Director Mater Health and CEO Mater
12.1 Suspension of Accreditation	Entire section	Director of Medical Services (SEQ) or Executive Officer

By-Law		In this By-Law, the "CEO or Delegate" means:
		(CNQ) and Regional Executive Director followed by report to Executive Director Mater Health and CEO Mater
12.2 Termination of Accreditation	Entire section	Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director followed by report to Executive Director Mater Health and CEO Mater
12.3 Imposition of Conditions	Entire section	Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director followed by report to Executive Director Mater Health and CEO Mater
12.4 Notification to Other Mater Health Facilities	Entire section	Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director followed by report to Executive Director Mater Health and CEO Mater
12.5 Conclusion and Expiry of Accreditation	Entire section	Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director followed by report to Executive Director Mater Health and CEO Mater
13.1 Rights of Appeal Against Decisions Affecting Accreditation	Entire section	Director of Medical Services (SEQ) or Executive Officer (CNQ) and Regional Executive Director followed by report to Executive Director Mater Health and CEO Mater
13.2 Appeal Process	a) A medical practitioner shall have fourteen (14) days from the date of notification of a decision to which there is a right of appeal to lodge an appeal against the decision. b) An appeal must be in writing, directed to the CEO or delegate and received by the CEO or delegate within the fourteen (14) day appeal period or else the right to appeal is lost. c) Unless decided otherwise by the CEO or delegate in the circumstances of a 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. d) Upon receipt of an appeal notice, the CEO or delegate will immediately forward the appeal request to the Board.	Executive Director Mater Health and CEO Mater
	e) The Board will nominate a Board delegate (who will be a member of the Board) to manage the appeal, which will include to provide instructions regarding the appeal, establish an Appeal Committee to hear the appeal and establish terms of reference. The Board will confirm in writing whether the decision of the Board pursuant to the	Board Director

By-Law		In this By-Law, the “CEO or Delegate” means:
	appeal process will be made by the Board or by the Board delegate (who will be a member of the Board).	
	f) The CEO or delegate will be responsible for provision of all relevant material to the chairperson of the Appeal Committee.	Executive Director Mater Health and CEO Mater
	g) The Appeal Committee shall comprise at least three (3) persons and will include: a nominee of the Board, who may be an Accredited Practitioner, who must not be involved in making the decision under appeal or involved in matters the subject of the appeal, and who will be the chairperson of the Appeal Committee; a nominee of the CEO or delegate, who may be an Accredited Practitioner, and who must not be involved in making the decision under appeal or involved in matters the subject of the appeal; any other member or members who bring specific expertise to the decision under appeal, as determined by the Board, and who must not be involved in making the decision under appeal or involved in matters the subject of the appeal, but who may be an Accredited Practitioner.	Board Executive Director Mater Health and CEO Mater Board
	h) 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 Board delegate will notify the appellant of the members of the Appeal Committee.	Board
	l) The CEO or delegate (or nominee of the CEO or delegate) may present to the Appeal Committee in order to support the decision under appeal. The nominee may be a lawyer.	Executive Director Mater Health / CEO Mater
	p) The Appeal Committee will make a written recommendation regarding the appeal to the Board or Board representative, 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 of the Appeal Committee has the deciding vote. A copy of the recommendation will be provided to the CEO (or delegate) and appellant.	Board Executive Director Mater Health or CEO Mater
	q) The Board or Board delegate will consider the recommendation of the Appeal Committee and make a decision about the appeal in its absolute discretion.	Board
	r) The decision of the Board or Board delegate is final and binding, and there is no further appeal allowed under these By-Laws from this decision.	Board
	s) The decision of the Board or Board delegate will be notified in writing to the CEO (or delegate) and appellant.	Executive Director Mater Health or CEO Mater

By-Law		In this By-Law, the "CEO or Delegate" means:
	t) If a notification has already been given to an external agency or agencies, then the CEO or delegate will notify that external agency or agencies of the appeal decision. If a notification has not already been given, the CEO or delegate, in consultation with the Board or Board delegate, 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.	Executive Director Mater Health or CEO Mater
14. Accreditation and Scope of Practice of Other Accredited Health Practitioners (not employed by Mater)	b) This By-Law 14 may also be utilised for other health practitioners (registered and non-registered) who do not fall into the categories outlined above with the process as modified by the CEO or delegate to suit the particular circumstances of the case.	Director of Medical Services (SEQ) or Executive Officer (CNQ)
	c) Applications for Initial Accreditation and Re-Accreditation should be submitted on the relevant form to the CEO or delegate.	Director of Medical Services (SEQ) or Executive Officer (CNQ) and followed by the Regional Executive Director
15. Amendments to, and Instruments Created Pursuant to the By-Laws	a) Amendments to these By-Laws can only be made by approval of the Board.	Board
	b) All Accredited Practitioners 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.	Board
	c) The Board may approve any annexures that accompany these By-Laws, and amendments that may be made from time to time to those annexures. The annexures once approved by the Board 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.	Board
	d) The CEO or delegate 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. These may include but are not limited to Accreditation and Scope of Practice requirements and the further criteria and requirements will be incorporated as criteria and requirements of these By-Laws.	Executive Director Mater Health, CEO Mater Health
16. Audit and Compliance	a) The CEO or delegate will establish a regular audit process, at intervals determined to be appropriate by the CEO or delegate or as may be required by a regulatory authority, to ensure compliance with the processes set out in these By-Laws relating to Credentialing and Accreditation, and any associated policies and procedures.	Executive Director Mater Health
	b) The audit process will include identification of opportunities for quality improvement in the Credentialing and Accreditation processes that will be reported to the CEO or delegate.	Executive Director Mater Health

3. Definitions

Term	Definition
Accredited Practitioner	A health practitioner who has been accredited to provide services at a Mater Health facility: within a specified accreditation category, accreditation type, facility service capability and scope of practice notified in the appointment. If not employed by Mater Health, the Accredited Practitioner may additionally be referred to as a Visiting Allied Health Professional, Visiting Dentist or Visiting Medical Officer, and Visiting Nurse Practitioner / Practice Nurse
Credentialing	In respect of an applicant for accreditation or re-accreditation, the formal process used to match the skills, experience and qualifications to the roles and responsibilities of that position. This will include actions to verify and assess the applicant's credentials, including the identity, 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, and other skills/attributes (for example in leadership, research, education, communication, teamwork), for the purpose of forming a view about the applicant's competence, performance, current fitness and professional suitability to provide safe, high quality health care to the standard required by Mater Health and with respect to the scope of practice sought. This includes recognition that the role of a Visiting Medical Officer Visiting Dentist or Visiting Allied Health Professional, Visiting Nurse Practitioner/Practice Nurse involves unsupervised clinical practice.
Credentialing Committee	A committee established under these By-Laws consisting of an appointed group of discipline specific representatives established for the purpose of recommending applications for accreditation and re-accreditation of applicants within the Facility. The Committee will be established to satisfy any statutory requirements applicable to the Facility with respect to credentials and scope of practice as well as any other internal requirements or external standards.
Credentialing System	The software utilised by Mater Health in recording all applicant and accredited practitioner personal and business information.
Clinical Researcher	Health Practitioner who is registered with the Medical Board of Australia (AHPRA) attending Mater health in the capacity of a clinical researcher and has approval from the Mater Health Human Research Ethics Committee (HREC) to conduct research study.
Clinical Visitor	A health practitioner registered with AHPRA or professional body other than a Medical Practitioner (see Medical Proctor), attending the Facility to further their own professional development, education and/or training through observation (no direct patient care) or supervised clinical practice.
Medical Observer / Proctor	A medical practitioner not currently accredited at Mater Health, who will not participate directly in the care of a patient of Mater Health and is present to further their own education and training through observation or is present to provide mentoring and guidance to an Accredited Practitioner.
Mater Health By-Laws for Accredited Practitioners	The overarching policy which describe medico administrative processes which apply to any and all Accredited Practitioners providing clinical services at Mater.
Medical Advisory Committee	The Medical Advisory Committee of each Facility.

4. Related documents and references

Mater documents

- Mater Misericordiae Ltd By-Laws
- Clinical Governance Framework

External documents

- Credentialing and Scope of Practice for Surgeons (2014). https://www.surgeons.org/about-racs/position-papers/credentialing-and-scope-of-practice-for-surgeons-2014
- Health Practitioner Regulation National Law Act 2009 https://www.legislation.qld.gov.au/view/pdf/inforce/current/act-2009-045
- Codes and guidelines for registration standards. Australian Health Practitioner Regulation Agency. (webpage reviewed 8/08/2018) https://www.ahpra.gov.au/Registration/Registration-Standards/codes-guidelines.aspx
- Health Ombudsman Act 2013 (current as at September 2017) https://www.legislation.qld.gov.au/view/pdf/inforce/2017-09-13/act-2013-036
- Australian Commission on Safety and Quality in Health Care. Clinical Governance Standard 2019. https://www.safetyandquality.gov.au/our-work/clinical-governance/clinical-governance-standard
- Medical Board of Australia. Expert Advisory Group on revalidation Final Report. 2017. Available from: http://Medical-Board---Report---Final-report-of-the-Expert-Advisory-Group-on-revalidation.PDF
- AHPRA, Medical Board of Australia. Professional Performance Framework. Reviewed 26/04/2018. Available at: https://www.medicalboard.gov.au/Registration/Professional-Performance-Framework.aspx
- Consultation on the draft Credentialing and Defining Scope of Clinical Practice: A guide for managers and clinicians

5. Document information

5.1 Revision history

Revision	Published date	Description
1	02 Jun 2020	Release of version 1 on the Mater Document Centre
1.1	01 Jun 2021	Updates with minor amendments; addition of Template 10 and minor addition to 2.12 (last paragraph)
2	02 Jul 2021	Version 2 published on the Mater Policy and Procedure Library – review and update in line with changes to Mater Misericordiae Ltd By-Laws

5.2 Key contacts

Author	Credentialing team
Area	Clinical Governance
Committee	Credentialing Governance Committee

Affirmation

This governance document is consistent with Mater's Mission.

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