Mater Health By-Laws 2024 – Summary for Accredited Practitioners

The Mater Misericordiae Limited (MML) Board have endorsed the Mater Health By-Laws for Accredited Practitioners (Mater By-Laws), effective from 1 April 2024.

This document is a summary only and accredited practitioners should read the full text of the By-Laws and relevant provisions.

An important change to the Mater By-Laws is the review of definitions and processes around accredited practitioner performance and how that is managed. Other changes are in response to recent organisational structure changes, role titles and role responsibilities within Mater. The new Mater Committee structure changes are reflected in these by-laws.

Mater By-Laws Part A – Definitions and Introductions

3. General matters and definitions

3.3 Definitions

- Updates to key definitions and to align to current Mater organisational structure and role titles / responsibilities and committee structure. In particular, addition of Credentialing Governance Committee definition, addition of new leadership roles definition (i.e., CMO) and an update on Performance definition.

3.4 Interpretation

- Where a specific role is mentioned and the role is temporarily or permanently vacated, the CEO shall define the appropriate role to fulfill this function.

Mater By-Laws Part B - Terms and Conditions of accreditation

5. Compliance with By-Laws

5.4 Insurance and registration

- Accredited Practitioners must at all times maintain adequate professional indemnity insurance relevant to the scope of practice granted.

5.5 Standard of conduct, behaviour and performance *(Improved definition of what Mater expects as a standard performance from accredited Practitioners and outlined measures and signals of safety and quality care expected to be similar to peers)*

- The Facility expects a high standard of performance from Accredited Practitioners, and that an individual Accredited Practitioner's measures and signals of safety and quality of care, are similar to peers in areas including but not restricted to:
  - i. Morbidity and mortality;
  - ii. Clinical Indictors of a Professional College;
  - iii. Clinical Care Standards;
  - iv. Speciality-specific outcome measures selected by a Craft / Specialty group;

v. Readmission with 28 days;

vi. Return to theatre;

vii. ICU admissions or transfers to another facility;

viii. Length of stay;

ix. Patient feedback ;

x. Clinical incidents;

xi. Hand hygiene compliance;

xii. Surgical Safety Checklist compliance;

xiii. Theatre utilisation (where applicable).

5.11 Voluntary Assisted Dying (VAD) *(Addition to reinforce the Code of Ethical Standards for Catholic Health and Aged Care Services in Australia, and that Accredited Practitioners will not facilitate or assist in VAD treatment or activities)*

- As a Catholic healthcare service, Mater Health adheres to the Code of Ethical Standards for Catholic Health and Aged Care Services in Australia and as such does not promote or facilitate treatments where the primary purpose is to terminate life.
- Accredited Practitioners will not facilitate or assist in voluntary assisted dying review and assessments of a Mater Health patient, in accordance with Mater Health's Statewide Policy – Requests for Voluntary Assisted Dying, even if the accredited practitioners are appropriately credentialed by State's administering authority to undertake this role unless authorised in writing by the CEO.

6. Commitment to safety and quality

6.1 Clinical practice and continuous improvement *(Outlines the role of quality forums including functions, objectives and engagement of these groups)*

- Attend and participate in safety, quality, risk management, education and training activities as requested, and as required by relevant legislation, standards and guidelines. This will include those standards and guidelines set by relevant Commonwealth or State governments, health departments or statutory health organisations charged with monitoring and investigating safety and quality of health care as well as facility or service accreditation bodies. Patient care and clinical service review processes are established within the Facility as part of a broader quality and safety (or clinical governance) program. Accredited Practitioners will participate in review of their clinical practice against best clinical evidence focusing on reducing unwarranted variation and meeting the organisation's expected standards of patient care.
- The processes referred to above may take a number of forms such as Craft / Specialty Group Meetings, Network Meetings, Morbidity & Mortality Meetings, Medical Advisory Committees that are established by the CEO or delegate as a platform to consider system improvements, learning and continual improvement.

  i. Each group, in consultation with the CEO or delegate, will establish the objectives and terms of reference for the group and will report on its activities through the governing committee structures set out by the Board and CEO or delegate.

  ii. The terms of reference referred to in (i) above will include the minimum number of attendances expected each year by an Accredited Practitioner. If no minimum number of attendances is set in the terms of reference, pursuant to these By-Laws the requirement will be to attend and participate in at least two (2) meetings per year (in person, via videoconference, telephone, in writing with chair of group or in discussion with chair of group) and any meeting in which a case, outcome or patient of that Accredited Practitioner is being considered. Attendances will be audited and considered by the CEO or delegate on an ongoing basis and as part of re-accreditation; and

  iii. The functions, objectives and engagement of groups will include:

    a. developing, implementing and reviewing policies, protocols, pathways, decision support tools and best practice guidelines in clinical areas to support best practice based on the best available

evidence; supporting safety and quality initiatives and programs of Mater Health and the Australian Commission on Safety and Quality in Health Care (including clinical care standards);

b. supporting accreditation and credentialing activities;

c. reflective practice and peer review, including but not limited to review of clinical outcomes and statistics relating to their own cases and cases of other Accredited Practitioners;

d. participating in audits of outcomes and processes of care; and

e. sharing new knowledge, new research and new practices.

6.4 Practice improvement meetings *(Removal of complete section, as 6.1 covers the content and simplifies the messaging)*

6.4 New procedures *(updated to ensure emphasis of risk-based approach for new procedures/technology etc new to Mater or new to Australia requiring review by the Credentialing Governance Committee)*

- Clinical Services, Procedures, Therapeutic Medicines, Therapeutic Goods, Medical Devices, Technologies or other Interventions (referred to as new procedure) that are new to the Mater, new to Australia will require review by the Credentialing Governance Committee.
- Accredited Practitioners proposing to introduce a new procedure will provide the Credentialing Governance Committee with supportive evidence to the satisfaction of the Committee 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.

6.5 Admission, availability, resources, communication and discharge *(Inclusion of video-conferencing)*

- Accredited Practitioners will thereafter review the patient within clinically appropriate timeframes, which at a minimum will ordinarily be in person 24 hourly, or through their on-call or locum cover, or via video-conference where the consultation is observed and documented by a Mater Health clinician present at the bedside. If Accredited Practitioners are unable to personally provide this level of care, the Accredited Practitioner will secure the agreement of another Accredited Practitioner to provide the care and will notify the Facility in writing of this arrangement.

6.7 Patient health records *(Emphasises requirement for completion of paper-based or electronic clinical forms, checklists, and pathways to support the delivery of safe care)*

- Paper-based and electronic clinical forms, checklists, and pathways that support the delivery of safe care, are completed.

6.10 Research *(Inclusion of below clause)*

- It is a condition of accreditation that all Accredited Practitioners will comply with the Mater Clinical Trial Governance Framework as it exists from time to time.

7. Part C – Accreditation of medical practitioners

7.4 Credentialing and accreditation *(Update regarding performance and review of performance data, inclusion of Nursing, Midwifery and Allied Health professional representatives on the Credentialing Governance Committee. Removal of credentialing principles as outlined within terms of reference and by-laws definitions – duplication)*

- Mater Health will also establish any requirements that must be met if accreditation is approved and prior to the exercise of accreditation, which may apply to all applicants or certain applicants based upon specified criteria. This may include a review of performance data, requirements for vaccination, police checks, fit testing for masks and any specialty specific requirements (e.g., colonoscopy re-certification).
- Credentialing processes will be governed by the Credentialing Governance Committee and operationalised by the Facility Medical Advisory Committee that will comply with any relevant requirements or standards applicable to the Facility.
- Concerns regarding a practitioner's competence and performance that are unable to be resolved at the Facility's Medical Advisory Committee, will be escalated to the Credentialing Governance Committee.

- Nursing, Midwifery and Allied Health professional representative will be members of the Credentialing Governance Committees.
- The principles to be considered as a guide for those persons involved in making decisions in the credentialing and accreditation process will be in accordance with the terms of reference and By-Laws.

7.5 Medical Advisory Committee *(Brief update of key terms of reference functions of the committee)*

- The Terms of Reference of the Medical Advisory Committee shall reflect the functions of the Committee including:
    i. Identifying and responding to operational and business matters, safety and quality concerns, risks and opportunities in the Facility.
    ii. Ensuring all Health Practitioners meet the minimum criteria to competently fulfil the duties of a specific position i.e., scope of practice.

7.6 Credentialing Governance Committee *(Addition, this committee provides strategic direction regarding new procedures, defines minimum specialty specific credentialing requirements, and is the mechanism for escalation of complex credentialing matters.)*

- The CEO or delegate will establish a single Credentialing Governance Committees for Mater. The Credentialing Governance Committees will function in accordance with approved terms of reference, requirements set out in these By-Laws along with any associated policies and procedures, and pursuant to any legislative obligations including standards that have mandatory application to the Facility and committee members.
- The Terms of Reference of the Credentialing Governance Committee shall reflect the functions of the Committee including:
    i. Providing strategic direction to Mater with respect to new procedures;
    ii. Defining the minimum criteria necessary for both credentialing and re-credentialing in each specialty area;
    iii. Being a mechanism for escalation for complex credentialing matters that may arise in a given facility.
- The Credentialing Governance Committee members, including the chairperson, will be Chairs of the Medical Advisory Committees and General Managers of each Mater facility, and appointed for periods as determined by the CEO or delegate.
- The CEO or delegate and members of the Hospital Executive or delegates will be entitled to attend meetings of the Credentialing Governance Committee as ex-officio members, and as such they will not have an entitlement to vote in relation to decisions or recommendations of the Credentialing Governance Committee.

8.3 Initial accreditation tenure *(Below clause reinstated, as was previously removed)*

- Where the initial accreditation period is less than five (5) years the CEO may reject an application for re-accreditation beyond that initial period and there shall be no appeal from that decision.

8.4 Consideration of application for re-accreditation by the CEO or delegate *(Inclusion of below clauses)*

- The CEO or delegate may grant approval for a temporary extension of credentials if a re-accreditation application is submitted prior to the expiration date and requires further time for the Credentialing Office to process and be considered by the relevant Medical Advisory Committee.
- The Credentialing Office prepare information with respect to credentials, referee reports, performance and activity volumes (including identified low-volume high-risk procedures), for consideration by the Medical Advisory Committee and/or Credentialing Governance Committee.

8.5 Re-accreditation tenure *(Addition, when performance of an Accredited Practitioner is significantly different to their peers there may be a requirement for supervision or individual case auditing)*

- Periods of re-accreditation less than five (5) years may be considered where the CEO or delegate considers more regular formal assessment is required of Competence, Performance and/or Current Fitness through a rigorous Credentialing process. This may include circumstances including but not limited to:

i. where it is determined that ongoing medical assessment and clearance will be required with respect to a physical or mental impairment, disability, condition, disorder or deterioration.

ii. where performance is significantly different to peers, and supervision and/or individual case auditing will be required.

17. Annexures *(All annexures have been removed. Summary of key committee functions is included within the by-laws and detailed within the terms of reference policies.)*