Title: Credentialling / Scope of Clinical Practice	Code:
	Category:

Osborne Park Hospital (OPH) shall provide timely access to credentialling and scope of practice process to facilitate medical practitioners maintaining the currency of their status. Medical practitioners practising within the definitions and scope of this policy are responsible for maintaining currency of their credentialling and scope of practice applicable to the work they are performing within OPH.

Policy	Procedures
The purpose of this policy is to inform medical practitioners who are practising at OPH of their rights and responsibilities regarding initial defining of clinical credentialling, unplanned credentialling, emergency situations, external disaster, emergency registration and credentialling, new clinical procedures/technologies/treatments and suspension of the right to practice inclusive of the appeals process.	

Endorsing Authority		**REFERENCES (STANDARDS)**
Policy Sponsor	**Medical Co-Director, OPH**	Office of Safety and Quality in Health: The Policy for Credentialling and Defining The Scope of Clinical Practice for Medical Practitioners (2nd Edition) Jan, 2009 Australian Council for Safety and Quality in Health Care: Credentialling and Defining The Scope of Clinical Practice Handbook, May 2005 Australian Council for Safety and Quality in Health Care: Standard for Credentialling and Defining The Scope of Clinical Practice, July 2004 Quality Improvement Council Core Module Standard 1.2 Medical Act 1897 Medical Practitioners Act 2008 DoH (2005) WA Clinical Services Framework 2005-2015. OP 1956/05 Provisional Registration of Medical Practitioners from Interstate in a Disaster Memorandum of Understanding (MOU) between the Minister for Health and the Australian Medical Association 2005 Department of Health Medical Practitioners AMA Industrial Agreements 2007
Initial Endorsement	February 2009	
Last Audited/Reviewed	February 2009	
Last Amended	February 2009	
Review Date	January 2010	
Standard		
EQuIP	**4th Edition**	
Legislation		
Standard	2.2, 3.1	
Criterion	2.2.2, 3.1.3	
Related Documents		

Policy	Procedures
<u>Definitions and Application</u> Credentialling is defined as "the formal process used to verify the qualifications, experience and professional standing of medical 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 organisational environments." Scope of Practice is defined as "delineating the extent of an individual medical practitioner's clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability, together with the needs and capabilities of the health facility itself." The Policy applies to all medical practitioners who are practising as independent medical practitioners or employees, including: • Consultants / Specialists • Health Service and Visiting Medical Practitioners • Senior Medical Practitioners • Senior Registrars/Fellows who have conditional registration with the Medical Board of WA and have been assessed by a Consultant(s) and a Credentialling Committee to be competent to perform operations/procedures unsupervised. • Vocational Registered General Practitioners who are seeking admitting rights to a public health facility • Clinical Academics • Unsupervised Overseas Trained Doctors, unsupervised International Medical Graduates, and unsupervised Overseas Trained Specialists • Medical Practitioners who are undergoing a supervised clinical assessment prior to a decision being made about their suitability to undertake procedural work in rural hospitals/Health Services • Medical Practitioners with a right of private practice in a public	**<u>Definitions and Application</u>** The members of the Hospital Executive, the Executive Officer(s) and the members of the Medical Executive Committee at OPH are to familiarise themselves with the 'WA Policy for Credentialling and Defining the Scope of Clinical Practice for Medical Practitioners' from the Office of Safety and Quality, and the local policy and procedures for OPH set out in this document (henceforth referred to as "The Policy"). The Policy and its relevant documents will be reviewed at least annually by the Medical Executive Committee, which advises the Medical Co-Director, who bears ultimate responsibility for Credentialling and Defining the Scope of Clinical Practice for Medical Practitioners at OPH. All correspondence relating to Credentialling and Defining the Scope of Clinical Practice for medical practitioners at OPH will be retained by the Executive Officer on behalf of the Medical Co-Director and the Executive Officer will be responsible for maintaining an up to date Credentialling Database of all relevant information. Access to the Credentialling Database will be afforded to the: • Hospital Executive (including Medical Co-Director) • Medical Executive Committee • Executive Officers of the Credentialling Committees • Heads of Clinical Service • Nurse Manager for theatres Hard copies of the Scopes of Clinical Practice will be provided to the theatre booking clerks. The Medical Executive Committee will nominate a representative of

hospital.

- Medical Practitioners providing telehealth services on behalf of OPH.
- Medical Administrator and Non-Specialist Qualified Medical Administrator, where that position involves direct patient contact or has a requirement for the provision of clinical services.

The Credentialling Policy *excludes* the following medical practitioners:

- Interns (PGY 1s) under supervision in a WA hospital
- Resident Medical Officers (PGY2, PGY3) and Registrars (PGY3+ - service or in training) enrolled in a recognised hospital-based training program under supervision in a WA hospital.
- Senior Registrars and Fellows fully or conditionally registered with an Australian Medical Board and enrolled in a recognised advanced training program supervised by an Australian Medical College that is a member of the Committee of Presidents of Medical Colleges (CPMC)
- Medical Practitioners undertaking research, if the research involves no patient contact or responsibilities.
- Medical Practitioners employed as Directors of Medical Services or Executive Directors at OPH, where that position does not contain any requirement for clinical services.
- Trainee Medical Administrators enrolled in a recognised hospital-based training program under supervision at OPH
- Trainee Public Health Physicians enrolled in a recognised hospital-based training program under supervision at OPH

The Policy and changes proposed to it will be agreed by the Medical Executive Committee at OPH. The Medical Co-Director is responsible for enacting the Policy.

OPH to attend the meetings of the NMAHS Credentialling Committee. The Medical Co-director will nominate a representative of OPH to attend those meetings of the KEMH Credentialling Committee at which matters of relevance to this site are to be discussed.

Credentialling and Scope of Clinical Practice

All credentialling processes must be fair, transparent and overseen by the relevant committee, which has responsibility for this function.

There are three distinct steps in credentialing and defining the scope of clinical practice of medical practitioners.

Initial credentialling

1. Verification of Credentials
2. Defining the Scope of Clinical Practice

Re-credentialling

3. Formal review of credentials and the scope of clinical practice

Medical practitioners undertaking clinical practice at OPH will be subject to the processes of the Credentialling Committee established by the North Metropolitan Area Health Service (on which there is an OPH representative) or King Edward Memorial Hospital, in the case of doctors practicing within the Women's and Newborn Clinical Service (henceforth referred to as the "relevant Committees").

The relevant Credentialling Committee will maintain comprehensive documentation of all deliberations, supporting evidence that was reviewed and decisions made about credentialling and determining the Scope of Clinical Practice for each medical practitioner at OPH.

The credentials required for professional appointment as a medical practitioner will be determined by the Committee, in consultation with the relevant medical colleges, if appropriate.

All matters related to the credentialing process will remain confidential to the relevant Committee and the professional concerned, but the summary information and outcome will be communicated to the OPH Medical Executive Committee and documented in the Credentialling Database to which authorised individuals will have access (see above).

Initial Credentialling (including mutual recognition of credentials)

Initial Credentialling (ie Verification of Credentials and Defining the Scope of Clinical Practice) will be undertaken as part of the employment / engagement process.

The Committee should develop and apply documentation / evidence that can be reviewed by the Committee prior to making a recommendation on a medical practitioner's ongoing scope of clinical practice.

Initial Credentialling (including mutual recognition)

An application for Initial Credentialling at OPH will be made to the Medical Co-Director. It should have the written support of the relevant Head of Clinical Service and provide consent to obtain relevant information from nominated referees. The Medical Co-Director may choose to discuss the application with the Head of Clinical Service and/or refer it to the Medical Executive Committee.

The Committee will verify the credentials of the medical practitioner. The Committee can recognise the credentialing processes of other WA credentialing committees, unless there are reasons to the contrary. Where a medical practitioner has a mutual recognition, the review date will be no later than the same date as the review date upon which the application is based.	If the application is supported and the applicant has already been credentialed by the relevant Committee (see above) within the last 3 years, then only the Scope of Clinical Practice need be defined. If the applicant was credentialed by the relevant Committee more than 3 years previously, then an application for Re-Credentialling may be more appropriate (see below). The documentation pertaining to the relevant Credentialling Committee and the Scope of Clinical Practice at OPH will be provided to the applicant by the Executive Officer at OPH. Completed applications which have the support of the Head of Clinical Service and the Medical Co-Director will be forwarded to the relevant Credentialling Committee for consideration at the next meeting. The outcome of the meeting will be notified to the applicant and the Executive Officer at OPH who will: • inform the Medical Co-Director, the Head of Clinical Service and the Medical Executive Committee. • complete the entry of relevant information into the Credentialling Database
Defining Scope of Clinical Practice The Medical Co-Director at OPH will be responsible for determining the Scope of Clinical Practice within the specific clinical specialties at OPH, based on the clinical service plan and resources available at that site.	**Defining Scope of Clinical Practice** The Medical Co-Director at OPH will determine the Scope of Clinical Practice within the specific clinical specialties through discussion with the relevant Heads of Clinical Service and members of the relevant Services Committees. The Scope will identify the procedures which can be performed at OPH and these will be reviewed annually by the Medical Executive Committee. The Scope of Clinical Practice will be defined or re-defined: • at the time of Credentialling and Re-Credentialling,

	• periodically at the request of the Medical Co-Director • in response to a request by the medical practitioner From the list provided, medical practitioners will be asked to nominate their own Scope of Clinical Practice for approval by the Head of Clinical Service and/or Medical Co-Director. This will be forwarded to the relevant Credentialling Committee. The Executive Officer will copy the agreed Scope of Clinical Practice to the: • medical practitioner • medical practitioner's personal file • theatre booking clerks and the • Credentialling Database. The Executive Officer will ensure that all medical practitioners on the theatre schedule for the current and succeeding 6 months have been credentialed and have had their Scope of Clinical Practice defined. If the theatre staff are concerned that a medical practitioner may not be appropriately credentialed or whose Scope of Clinical Practice does not include a planned procedure, they should bring it to the attention of the Medical Co-Director through the Nurse Manager as soon as possible.
Unplanned Credentialling /Temporary Credentialling Unplanned credentialling may be undertaken at the request of the hospital Executive, other staff members or the individual.	**Unplanned Credentialling /Temporary Credentialling** Requests for unplanned credentialling are to be made to the Medical Co-Director who, if necessary, will liaise with the Chairman of the

Temporary credentialling should be for a specified time frame after which it ceases. Formal credentialling, for medical practitioners appointed to the hospital, should be completed before the temporary credentialling period expires.	relevant Credentialling Committee and/or Head of Clinical Service. Under these circumstances credentialing will involve at a minimum: • verification of identification, • verification of professional registration and any conditions which would limit the ability to fulfil the requirements of the role, • review of employment history, • Criminal Record Check, and Working with Children Check, where appropriate, • at least one referee report, preferably from the most recent employer. An interim Scope of Clinical Practice should be defined. The Medical Co-Director and/or a senior medical practitioner who works in the same specialty as the applicant (if the applicant is not already known to the Head of Clinical Service) may interview the applicant, if necessary by phone. Temporary credentialling should be fully documented in the individual's personal file and limited to 6 months at most. Temporary credentialling should be referred to the next meeting of the relevant Credentialling Committee for formal consideration and approval.
<u>Re-Credentialling</u> The Medical Co-Director will be responsible for determining a regular and on-going schedule for re-credentialling medical practitioners. At a minimum, it is undertaken as part of the re-employment process, usually every 3-5 years.	**<u>Re-Credentialling</u>** The Executive Officer at OPH will maintain the Credentialling Database and ensure that medical practitioners undergo Re-Credentialling as part of the re-employment process, or no less frequently than every 5 years. The Executive Officer will provide the

The Department of Health checklist of documentation / evidence should be implemented and reviewed by the Committee prior to making a recommendation on a medical practitioner's re-credentialling.

Emergency Situations

Credentialed medical practitioners are permitted to act outside their authorised scope of clinical practice in an emergency situation when a patient may be at risk of serious harm if treatment is not provided, and no medical practitioner with an authorised Scope of Clinical Practice is available.

medical practitioner with the Re-credentialling documentation of the relevant Credentialling Committee and the OPH Scope of Clinical Practice document relating to his/her subspecialty or subspecialties. The completed application will be reviewed by the Head of Clinical Service and/or the Medical Co-Director prior to submission to the relevant Credentialling Committee.

The Committee shall review the checklist of documentation, and in addition, the committee should review:

either
declarations provided that there has been no change to the previous information regarding:

- Defined scope of clinical practice or denial, suspension, termination or withdrawal of the right to practise (other than for organisational reasons).
- Any disciplinary action or professional sanction imposed by the Medical Board of WA.
- Any criminal investigation or conviction.
- The presence of any physical or mental condition or substance abuse problem that could affect the medical practitioner's ability to exercise the scope of clinical practice requested or that will require special assistance to enable him /her to do so safely and competently.

or
a declaration describing the specific changes to information related to the aspects listed in the clause above.

Emergency Situations

The medical practitioner, acting outside his/her Scope of Clinical Practice in an emergency situation, is to provide to the Medical Co-Director as soon as practicable:

- details of the incident,

In the event that an emergency at OPH requires specialist medical assistance from an external source the Medical Co-Director is to contact his / her equivalent position holder at the site where the medical practitioner is credentialled to confirm that he / she is registered and has the necessary clinical skills to assist in the emergency.

External Disaster: Emergency Registration and Credentialling

In the event of a major health disaster or emergency within Western Australian that impacts upon services at OPH the Department of Health will ensure that an efficient response is activated. If it is determined that current resources are insufficient to effectively manage the emergency it may be necessary to obtain medical assistance interstate.

If this situation occurs the State Health Coordinator will advise the Director General that external medical assistance is required and, upon receiving approval, will contact the Executive Officer, State Emergency Management Committee who will submit a request to Emergency Management Australia for coordination.

The Director General or his delegate will request provisional registration of medical practitioners on the interstate team for up to 3 months with the Medical Board of WA. The delegate, in most circumstances, will be the Director, Disaster Preparedness and Management.
Once approved, the list of provisionally registered interstate medical practitioners will be provided to the Director General or his delegate and the NMAHS Area Executive Director - Medical will be informed.

Any administrative costs associated with the provisional registration will be borne by the Department of Health.

- actions taken and
- outcome of these actions

Depending on the circumstances, the Medical Co-Director may:

- take no further action
- institute an investigation
- inform the Chairman of the Credentialling Committee of the incident.
- record details of the incident in the practitioner's file

External Disaster: Emergency Registration and Credentialling

Upon receipt of confirmation of provisional registration for interstate medical practitioners the Medical Co-Director or nominated deputy should:

- verify the identity of each medical practitioner through inspection of relevant documents, eg driver's license.
- contact a member of the senior organisation nominated by the medical practitioner as his / her most recent place of appointment to verify claimed employment history and good standing.
- confirm the medical practitioner's competence and good standing, as soon as practicable, by contacting at least one professional referee.

Where practicable, an assessment of the medical practitioner's credentials should be undertaken by a senior medical practitioner who works in the same specialty.

The emergency credentialling procedure for each medical practitioner is to be documented and retained in the hospital records.

New Clinical Procedures/Technologies/Treatments	**New Clinical Procedures/Technologies/Treatments**
OPH will ensure there are processes that define the requirements for introducing new clinical services, procedures or other interventions. As new procedures and treatment modalities are developed and introduced to a site, medical practitioners must have their Scope of Clinical Practice amended, as appropriate, to provide for these developments. The introduction of new procedures, technologies and treatments to Osborne Park Hospital must be done in a manner that ensures patient safety and welfare. They should only be introduced when their clinical benefit is proven or the likelihood of clinical benefit is proven, and when the individual practitioners can extract the clinical benefit from them. Failure to adequately assess new procedures, technology and treatments, and credential medical practitioners appropriately may place patients at risk of harm and the hospital at risk of legal liability. If there is doubt about the safety of the procedure, technology or treatment then approval should not be given to proceed. For further information refer to OPH Policy for the Introduction of New Clinical Procedures, Technologies or Treatments.	The use of a new drug or blood product at OPH should be considered by the combined Drug and Therapeutics/Transfusion Committee according to its Terms of Reference. The use of an expensive new drug, as defined by WADEP, may be referred to that Panel for consideration if it has not already been reviewed. The relevant application forms are available from the WATAG website. Restrictions placed on the use of drugs by WATAG should be considered by the Drug and Therapeutics Committee, but the decision to provide the drug through OPH rather than one of the tertiary sites, will depend on the availability of funding. In the ensuing discussion of new procedures, technologies or treatments, drugs subject to these processes will not be considered further. However the Drug and Therapeutics/Transfusion Committee may choose to refer the use of new blood products for consideration as a new technology.
Suspension of the Right to Practice The Medical Co-Director may, upon receiving advice from the relevant Credentialling Committee or in response to clinical incidents or concerns, suspend either permanently or temporarily, in part or in full, a medical practitioner's right to practice. In addition, the OPH Executive may decide that a clinical service is no longer to be provided or that it no longer requires the clinical services,	**Suspension of the Right to Practice** In suspending a medical practitioner's right to practice: • The correct procedures set out in the relevant contract or Agreement for suspending a medical practitioner's right to practice are to be followed. • The Human Resources Department is to be consulted if the

procedures or interventions, which were previously included in a medical practitioner's scope of clinical practice. Significant concerns about a medical practitioner's competence and/or fitness to practice are to be referred to the Medical Board of WA.	suspension is due to poor performance or lack of competency. • The Medical Co-Director is to inform the medical practitioner of the suspension of his/ her right to practice at OPH and provide comprehensive details of the reason for this decision. • The reasons for the suspension of the medical practitioner's right to practice are to be documented in his/her personal file. • The Chairman of the relevant Credentialling Committee is to be informed. • The Area Executive Director - Medical is to be informed if there is concern that the medical practitioner's competence and/or current fitness to practice at OPH, is at a level that patient safety and the quality of health care will be significantly affected. • The Medical Co-Director will refer the matter, if relevant, to the Medical Board of WA and be responsible for all ensuing correspondence with them.
Appeals A medical practitioner, whose right to clinical practice has been fully or partially suspended, may appeal this decision.	**Appeals** • The correct procedures set out in the relevant contract or Agreement for suspending a medical practitioner's right to practice are to be followed. • The suspended medical practitioner is to provide, in writing, to the Medical Co-Director the reasons why the decision to suspend him/her should be rescinded and supply any supporting documentation. • If the decision is related to the medical practitioner's competence to practice the appeal will be referred to the relevant Credentialling Committee for review. • The Committee is to undertake a thorough review of all circumstances and documentation and is to conduct interviews with relevant professionals before deliberating on whether or not the appeal should be upheld.

	• The medical practitioner and the Medical Co-Director are to be informed about the outcome of the appeal by the Chairman of the Credentialling Committee. If the suspension is related to a change in the provision of clinical services at OPH the matter is to be referred to the relevant Area Executive Director Medical and, if necessary, to the Area Chief Executive NMAHS.