CLINICAL RISK	RHC Policy No: CG 01:011:29:00P

Policy Title:	Credentialing & Scope of Practice of Health Professionals

Ramsay Health Care recognises that the principal responsibility for a patient's care lies with that patient's doctor. Following consultation with doctors and clinical employees, and through reference to current industry best practice standards, we have developed this policy as a minimum standard designed to deliver optimal care to patients. ***Facility management and relevant RHC employees must comply with this policy*** *and integrate these minimum standards into the facility's clinical systems and RHC employees' individual practice.*

POLICY PURPOSE and OUTCOME:	**Purpose** To outline the process for Credentialing, Re-Credentialing and Scope of Practice for Health Professionals and Allied Health Professionals working in Ramsay Health Care (**RHC**) Facilities. **Outcome:** • To maintain and improve the safety and quality of clinical care.
POLICY SCOPE:	This policy applies to all Health Professionals and Allied Health Professionals seeking accreditation at a RHC Facility.
DEFINITIONS:	**Accredited Allied Health Professional (AAHP):** an Allied Health Professional authorised to treat patients at the Facility within a designated Scope of Practice and in accordance with any specified conditions. (RHC Facility Rules) **Allied Health Professional (AHP):** a cardiac technician, chiropractor, dietician, occupational therapist, pharmacist, physiotherapist, podiatrist, psychologist, speech pathologist, social worker, rehabilitation counsellor or other category of person who provides allied health services, as determined by the RHC Australian Risk Management Committee (**ARMC**). For the purpose of the RHC Facility Rules, a reference to an Allied Health Professional includes any Complementary Health Provider and a reference to allied health services includes complementary health services. (RHC Facility Rules) **Accredited Practitioner (AP):** a Health Professional authorised to treat patients at the facility within a designated Scope of Practice and in accordance with any specified conditions. (RHC Facility Rules) **Credentialing**: the formal process used by a health service organisation to verify the qualifications, experience, professional standing, competencies and other relevant professional attributes of clinicians, so that the organisation can form a view about the clinician's competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments. (ACSQHC 2017) **Facility:** means a hospital or day procedure centre of Ramsay Health Care. **Health Professional**: a medical practitioner, dentist or medical radiation practitioner. **Re-Credentialing**: the formal process used to re-confirm the qualifications, experience and professional standing (including history of and current status with respect to professional registration, disciplinary actions, indemnity insurance and criminal record) of clinicians, for the purpose of forming a view about their ongoing competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments. (ACSQHC 2017) **Scope of Practice**: the extent of an individual Health Professional or Allied Health

	Professional's approved clinical practice within a particular organisation, based on the person's skills, knowledge, performance and professional suitability, and the needs and service capability of the organisation. (ACSQHC 2017)
POLICY STATEMENT and MANDATORY REQUIREMENTS:	RHC Accredited Practitioners and Accredited Allied Health Professionals are appropriately skilled and experienced to perform their roles safely and provide services within their agreed Scope of Practice. **The minimum mandatory requirements are:** Health Professionals and Allied Health Professionals seeking accreditation at a RHC Facility must submit a completed application form to the Facility's Chief Executive Officer using Ramsay's electronic credentialing system. (Refer Appendix A eCredential Workflow Process – Initial Application) Upon verification that the application is complete, including appropriate registration, professional indemnity insurance, referee reports and licensing where applicable, and subject to the Facility Chief Executive Officer's right to reject any application, the Facility Chief Executive Officer will forward the application to the Facility Credentials Committee. The Facility Credentials Committee will review all applications referred to it with respect to the credentials, qualifications, experience, competence, judgement, professional capabilities and knowledge, current fitness, character and confidence held in the applicant and formulate recommendations to the Medical Advisory Committee (**MAC**) on each applicant's credentials, accreditation classification and Scope of Practice. The MAC will review the recommendations of the Facility Credentials Committee and recommend to the Facility Chief Executive Officer whether the application for accreditation should be approved, and if so, the appropriate accreditation classification and Scope of Practice for the applicant. The Facility Chief Executive Officer will submit the recommendations of the MAC together with the Facility Chief Executive Officer's advice on accreditation including Scope of Practice to Ramsay Health Care Australia's Central Credentialing Committee through the National Clinical Governance Unit. The Central Credentialing Committee, with the advice of the National Clinical Governance Unit, will determine whether and under what conditions accreditation should be offered. **New South Wales, Queensland, Western Australian and South Australian Facilities** In New South Wales, Queensland, Western Australia and South Australia, a Health Professional or Allied Health Professional may be accredited to treat patients at the facility for a period of up to **five (5) years**. **Victorian Facilities** In Victoria, a Health Professional or Allied Health Professional may be accredited to treat patients at the Facility for a period of up to **three (3) years** (as detailed in the *Health Services (Health Service Establishments) Regulations 2013* (VIC)). **Temporary Credentialing** In some instances, temporary credentialing may be required to authorise temporary accreditation of a Health Professional or Allied Health Professional to facilitate caseload surges and/or workforce deficiencies, during natural and environmental disasters, or at times of epidemic and pandemic preparedness. Temporary approval can be authorised by the Facility Chief Executive Officer (or the Director of Medical Services, where one has been appointed, with delegated authority) following submission of an online credentialing application and verification of the AHPRA registration and indemnity insurance details contained in the application, in accordance with the RHC Facility Rules. The Facility Chief Executive Officer, in consultation with the MAC and/or Head of the relevant Clinical Department, can authorise temporary accreditation for a specified period of no longer than **three (3) months**. Upon approval of temporary privileges, the

	Facility Chief Executive Officer will notify the applicant in writing, advising the accreditation classification, Scope of Practice and expiry date. The application will then progress through the usual review and approval processes. **Re-credentialing:** Not less than three (3) months before the date fixed for expiry of the accreditation of an Accredited Practitioner or Accredited Allied Health Professional, the Facility Chief Executive Officer will notify the Accredited Practitioner or Accredited Allied Health Professional of the pending expiry of their accreditation and the processes for applying for re-accreditation, including Re-Credentialing and review of their Scope of Practice. (Refer Appendix B eCredential WorkFlow Process – Reappointment) **Process of review of Accredited Practitioners and Accredited Allied Health Professionals:** At any time, the Facility Chief Executive Officer, Director of Clinical Services, Director of Medical Services, Head of a Clinical Department in which a Health Professional or Allied Health Professional practises, National Clinical Governance Unit, Operations Executive Manager, Chief Executive Officer of Ramsay Health Care Australia, Chief Operating Officer of Ramsay Health Care Australia or Ramsay Health Care Australian Risk Management Committee may request a review of an Accredited Practitioner or Accredited Allied Health Professional. Please contact the relevant Facility Chief Executive Officer if you have any questions about the process for Credentialing or Scope of Practice. **Process of continually assessing health service:** The Facility Chief Executive Officer must establish and maintain a MAC. One of the roles of the MAC is to ensure that a process for review of clinical outcomes and patient management is established and executed. Ordinary meetings of the MAC must be held not less than four (4) times per year. In addition to the MAC, the Facility Chief Executive will establish a Patient Care Review Committee. The primary role of the Patient Care Review Committee is to develop and oversee the implementation of an adequate clinical review and quality improvement program in liaison with Clinical Departments or services for each twelve (12) month period, and to review the results of the clinical indicator program including: • rates of unplanned transfers in and out of the Facility and in and out of special care units; • returns to theatre and deaths; and • other clinical risks as identified by the committee. Meetings of the Patient Care Review Committee will be held no less than four (4) times per year.
ROLES AND RESPONSIBILITIES	
Ramsay Health Care Australia's Central Credentialing Committee	• Reviews recommendations from Facility Chief Executive Officers regarding the appointment of Accredited Practitioners and Accredited Allied Health Professionals.
NCGU	• Coordinate and maintain credential database. • Support Facility staff in the Credentialing process.
Facility Chief Executive Officer (CEO)	• Review applications for accreditation. • Approve or reject applications for accreditation. • Provide temporary accreditation, where approved.

	• Provide Clinician orientation to the Facility.
Facility Medical Advisory Committee	• In consultation with the Facility Chief Executive Officer, review and approve applications for temporary accreditation.
Accredited Practitioners/ Health Professionals and Accredited Allied Health Professionals/ Allied Health Professionals	• Submit all appropriate and required documentation for accreditation in a timely manner. • Once accredited, works in accordance with RHC Facility Rules.
RELATED POLICIES, PROCEDURES, GUIDELINES & FORMS:	• RHC Facility Rules • RHC Accredited Practitioner/Accredited Allied Health Professional Orientation Manual • RHC Intranet – NCGU Credentialing

Prepared By:	National Clinical Governance Unit (NCGU)	January 2022
Reviewed and endorsed by:	Clinical Governance Committee (CGC)	March 2022
Date Implemented:	**March 2022**	
Next Review Due:	**March 2025**	

REVISION HISTORY

Date	Version	Amendment notes
February 2019	V1.0	Initial Release
August 2020	V2.0	Policy originally developed to cover Victoria only due to 3-year credentialing period. Amendments to Policy to include NSW, QLD, WA & SA. Addition of Temporary Accreditation process
March 2022	V3.0	Updated contents

This policy is due for review by the date shown above, after which it may become invalid. Policy users should ensure that they are consulting the currently valid version of the document.

Appendix A - eCredential Workflow Process

Appendix B – eCredential Workflow Process – Reappointment