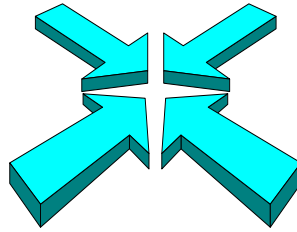


## Confederation of Postgraduate Medical Education Councils



### **Response to the NRAS consultation paper on proposed arrangements for accreditation**

#### *Introduction*

The Confederation of Postgraduate Medical Education Councils (CPMEC) is the peak body for State and Territory Postgraduate Medical Councils (PMCs) or equivalent in Australia, and also has collaborative membership with the Education Committee of the Medical Council of New Zealand.

A key role that nearly all Postgraduate Medical Councils play is accreditation of Postgraduate Year 1 (PGY1) internship training positions as a prerequisite for general registration with Medical Boards. Increasingly, many PMCs are now also undertaking accreditation beyond PGY1 to ensure quality of training, supervision and performance of all those in the first two years of prevocational medical training. In addition, a number of the PMCs are now committed to the assessment and up-skilling of International Medical Graduates who laterally enter the medical workforce and are not part of any vocational college training program. It is pertinent to note that the lack of any designated national education and training body covering the undifferentiated prevocational trainees, most IMGs and career medical officers will pose a significant challenge to the functions of the planned national medical board and accrediting authority.

CPMEC would like to reiterate that high quality prevocational medical education and training provides the foundation for subsequent specialist and general practice training. Prevocational doctors play a key role in the operation of health services, and their numbers will expand significantly over the next few years.

The accreditation function is delegated to PMCs by State and Territory Medical Boards and ensures that doctors working towards initial registration and beyond receive appropriate training and that supervision standards are met. These standards are integral to the provision of high quality and safe patient care. Accreditation visits for prevocational training usually involve of a range of professionals including clinicians, hospital managers, medical education officers (non-medical) and prevocational trainees.

Whilst some of our earlier concerns have been addressed, CPMEC and member PMCs still remains anxious about recognition of prevocational medical education and training in the transition to national registration and accreditation. As we have highlighted previously, PMCs have developed considerable expertise in accreditation

processes with respect to hospital training positions and we are concerned that there has been very little mention of strategies to maintain the quality of this prevocational phase of the medical education and training continuum.

In response to the NRAS Consultation Paper, we would like to highlight the following:

1. Role of AMC

As noted in our previous submissions, CPMEC has been very supportive of the AMC being given a role to accredit PMCs to ensure that they have responsibility for accreditation of training across the whole medical education and training continuum. To facilitate this, AMC and CPMEC have been in dialogue on a mechanism for doing so. The role of the AMC has also been supported in a joint submission on medical accreditation that CPMEC has made with peak medical educational organisations. Clearly AMC & CPMEC would need the approval of jurisdictional health departments to allow for finalisation of any such proposal before the national scheme comes into effect in July 2010.

The approach of giving AMC a lead role would fit in with accreditation arrangements referred to in Page 8 of the NRAS discussion paper where *“the accrediting body (the AMC in this case) accredits a second body or bodies (the PMCs), which then accredit/s the training providers and/or training settings”*.

To facilitate a nationally consistent approach to the accreditation of prevocational education and training, CPMEC in conjunction with all Postgraduate Medical Councils has developed a draft national Prevocational Medical Accreditation Framework (PMAF) that was launched for consultation in November 2008. The project has been recognised as a national priority in prevocational medical education with project funding provided by the Australian Government Department of Health and Ageing.

The PMAF aims to increase consistency across the jurisdictions of accreditation practices, align prevocational accreditation practices with other appropriate local and international benchmarks, reduce duplication of work required in each PMC (or its equivalent), and provide increased transparency of accreditation practices. It would fit in well with COAG initiatives towards achieving national accreditation in the health professions. CPMEC considers that the PMAF, when finalised, could form the basis of the proposed accreditation of PMCs by the AMC. This function will require resources for its implementation. A copy of PMAF is attached to this submission.

2. Scope of accreditation arrangements

The consultation paper notes that *“Through a voluntary system, the post-graduate training organisations and the specialist medical colleges all participate in a quality assurance and quality improvement process run by the AMC, which may include a re-accreditation process”* (p 8).

Whilst recognising the strategic intent of the CPMEC and AMC in (1) above, it still needs to be emphasised that AMC does not currently accredit PMCs nor has responsibility for accreditation of prevocational training. CPMEC and its members are concerned that there has been insufficient attention given to accreditation

arrangements for the prevocational phase in medical education and training in discussions concerning transitional arrangements to a national scheme.

In this respect CPMEC is actively exploring issues surrounding the conditions for registration of interns under a national registration and accreditation scheme. There should be a high degree of uniformity of the internship structure across the jurisdictions with respect to supervision and training activities to meet required competencies in clinical management, communication and professionalism. These are outlined in our *Australian Curriculum Framework for Junior Doctors* and have been widely adopted by clinical educators throughout Australia (and abroad). Resources are being sought to support the conclusion of this process.

### 3. Core accreditation functions

CPMEC is of the view that the core accreditation functions as defined on Page 13 of the discussion paper need to be expanded. Currently PMCs are responsible for development of standards and assessment of the capacity of every individual hospital unit with trainees to provide the appropriate training for these prevocational doctors to meet registration requirements of State and Territory Medical Boards. We believe that definition should be expanded to include reference to accreditation of such training positions in hospital and other settings, in addition to courses of study.

### 4. Governance arrangements

Whilst CPMEC is comfortable with most of the other proposals outlined in the discussion paper, some concerns in relation to specific items are noted:

- a. In relation to governance arrangements for external accreditation bodies, CPMEC supports the input of education providers, community bodies and the profession (including junior doctors in the case of prevocational medical training accreditation) through peak body nominations. However, it is concerned that the composition of the Accreditation Committees (Proposal 3.6.1) should not result in a dilution of expertise on accreditation matters.
- b. In relation to Proposal 3.6.2, COAG might consider the appointment of an independent Chair as an option.
- c. In relation to 3.7.1, CPMEC supports the right of an aggrieved party to a process review by the board of a decision made by the accreditation body. However, we are concerned that any merit review should not compromise standards unless required by overriding legal requirements.
- d. In relation to reports, there is a need to be mindful of the unintended consequences of making all accreditation reports publicly available. There is the risk of some hospitals being inappropriately judged from initial draft reports raising issues to be addressed and not being able to attract quality intern applications. An option may be to publish final reports summarising key issues emerging from accreditation visits.

### 5. Resourcing of prevocational medical accreditation activities

CPMEC members remain very concerned about the resourcing arrangements under the national registration and accreditation scheme. Currently PMCs or equivalent are funded for their accreditation activities by their State or Territory Medical Boards and/or State Health Departments. Unlike Colleges and Medical schools, PMCs do not

have the facility to charge fees and would continue to rely on external funding to carry out their responsibilities with respect to prevocational medical training and education accreditation.

Prepared by CPMEC

16 December 2008



## **PREVOCATIONAL MEDICAL ACCREDITATION FRAMEWORK (PMAF)**

### **for the Education and Training of Prevocational Doctors in Australia**

## **PREAMBLE**

### **ACCREDITATION**

*'Accreditation is a formal process by which a recognised body, usually a non-governmental organisation, assesses and recognises that a health care organisation meets applicable pre-determined and published standards. Accreditation standards are usually regarded as optimal and achievable, and are designed to encourage continuous improvement efforts within accredited organisations. An accreditation decision about a specific health care organisation is made following a periodic on-site evaluation by a team of peer reviewers, typically conducted every two to three years.'*<sup>1</sup>

Both an outcome and a process, accreditation relies on thoughtful and principled judgment based on evidence, measured with integrity against rigorous requirements, and a context of trust. Accreditation provides an assessment of effectiveness in the fulfilment of a mission, compliance with the requirements of an accrediting association, and the continuing effort to enhance the quality of learning, programs and services. The process stimulates evaluation and improvement, while providing a means of continuing accountability to stakeholders and the public. The outcome of accreditation is a statement of continuing capacity to provide effective programs and services based on agreed-upon requirements.

The accreditation program is a quality assurance process that establishes and monitors standards for Prevocational Doctors, and assists in the attainment of a universally high standard of general clinical training. Accreditation helps to

ensure that a supportive environment exists for the organisation, supervision and training of Prevocational Doctors.

The aim of general prevocational clinical training is to further the personal and professional development of doctors in prevocational training. Training posts should enable graduates to develop confidence, clinical knowledge and skills, and a maturity of judgment necessary for safe and competent medical practice. These posts should offer well organised and accessible supervision, education and experience. Prevocational Doctors must not be rostered to unaccredited units.

Through the processes of accreditation, a professional survey team, using the clearly defined and established standards, formally evaluates networks, facilities, units and practices that employ Prevocational Doctors. A fundamental aspect of the accreditation process is continuous quality improvement to enhance the quality of learning, educational programs and service delivery.

## CONTENTS

The PMAF document contains 4 main sections:

**Elements** (pg. 3) are an annotated index to the major themes covered in the PMAF.

**Principles** (pg. 5) are general statements of intent to underpin the implementation of accreditation policies, processes and procedures.

**Policies** (pg. 12) have been defined as rules which must be adhered to in regard to the Accreditation Process.

**Glossary** (pg. 26) provides definitions of important terms used in the PMAF document.

Not included in the PMAF document are:

**Processes** that have been defined as systems for multiple stakeholders to follow at differing stages in the Accreditation Process. Specific processes are not detailed in this Framework but are determined by the needs of the individual Postgraduate Medical Councils or equivalent.

**Procedures** that are for local implementation, and guide the training organisation being accredited in the specific steps and timelines for a component of a process. Specific procedures are not detailed in this Framework but are determined by the needs of the individual Postgraduate Medical Councils or equivalent.

1. Rooney, A.L., van Ostenberg, P.R. *Licensure, Accreditation and Certification: Approaches to Health Services Quality*. Quality Assurance Project, Bethesda USA, 1999.



## ELEMENTS

This paper builds on the work done by the Postgraduate Medical Council of Queensland.

<b>SUGGESTED CONTENTS OF PMC ACCREDITATION PRINCIPLES</b>		
<b>Page</b>	<b>TOPIC</b>	<b>SOME POSSIBLE EXAMPLES</b>
<b>5</b>	<b>1. INTRODUCTION</b>	
5	1.1 Definitions	Definitions of important terms.
5	1.2 Aims of Accreditation	Aims of accreditation. Purpose and scope of the accreditation system. Description of PMC or equivalent.
6	1.3 Context of Accreditation	Describes the context of accreditation.
6	1.4 Scope of Accreditation	Describes the scope of accreditation. Pre-registration and other prevocational doctors' training positions.
<b>7</b>	<b>2. PRINCIPLES of ACCREDITATION</b>	
7	2.1 General Principles	Valid, reliable processes. Not burdensome. Consistent with international. Legal. Fostering improvement and excellence. Improved patient care.
8	2.2 Process Principles	Suits registration needs. Monitored by a Committee. Founded on standards. Cycle with stages. Regular review. Evaluation used. Appeals mechanism. Consistent with other PMCs.
<b>9</b>	<b>3. STANDARDS of ACCREDITATION</b>	
9	3.1 Governance Standards	Governance, organisation and administration of the training and education program; Structure and content of the training and education program; Supervision of Prevocational Doctors; Assessment of Prevocational Doctors; Evaluation by Prevocational Doctors of their programs and supervisors; Orientation of Prevocational Doctors; Procedures for ongoing evaluation of the training program; Welfare concerns of Prevocational Doctors; Resources and facilities for Prevocational Doctors.
10	3.2 Prevocational Training and Education Program Standards	Term orientation and handover; Structure and content of the training and education program; Supervision of Prevocational Doctors; Assessment of Prevocational Doctors; Clinical opportunities / term content.
<b>11</b>	<b>4. CONTINUITY</b>	
11	4.1 Sustainability	Mutual recognition and respect; Resourcing – personnel, finance and infrastructure; Efficiency; Integrity and fairness; Validity and reliability; Continuity; Allowance for diversity; Capacity for evolution and continuous improvement

<b>SUGGESTED CONTENTS OF PMC ACCREDITATION POLICIES</b>		
<b>Page</b>	<b>TOPIC</b>	<b>SOME POSSIBLE EXAMPLES</b>
<b>12</b>	<b>5. SYSTEM OVERSIGHT AND GOVERNANCE POLICIES</b>	
12	5.1 Resourcing and Funding of the Accreditation System	The Accreditation Committee and secretariat should be appropriately resourced. Describes how reviews and visits will be funded.
13	5.2 Scope of Accreditation	Positions / Terms. Training organisation. Network / hub. (Does the accreditation process survey individual terms (units) as well as the facility as a whole?)
14	5.3 Application and Reapplication for Accreditation	Describes how, when and why.
15	5.4 Assessment Policy and Feedback to Stakeholders	Describes who will evaluate, when and with which tools.
15	5.5 Conflicts of Interest	Obligation to declare conflict of interest. Describes how conflicts of interest should be addressed.
16	5.6 Confidentiality	Implicit or explicit statement by surveyors. Protection of data.
17	5.7 Appeals Policy	Describes the principles, rules and grounds of appeals against accreditation decisions.
18	5.8 Transparency and Publication of Results of Accreditation	Describes PMC role in disseminating information about results of reviews, and methods used.
18	5.9 Surveyor Recruitment, Training and Management	Describes the selection and composition of membership, qualifications, survey training and experience, responsibilities, and confidentiality. Liability / insurance / indemnity.
20	5.10 Supervision	Describes minimum expectations for supervision of Prevocational Doctors by the PMC or equivalent.
21	5.11 Review of Accreditation System	Describes how and when review of accreditation processes and standards will be conducted.
<b>22</b>	<b>6. POLICIES ON SURVEYS</b>	
22	6.1 Reviews and Visits of Facilities	Notes how and when review of accreditation processes and standards will be conducted. What prompts a review or a visit. composition of a survey team. Duration and scope of visits. Other review opportunities e.g. by paper.
23	6.2 Levels of Compliance to Accreditation Standards	What level of accreditation may be granted e.g. 5 level statements or 4 level statements (Little Achievement, Some Achievement, Moderate Achievement, Extensive Achievement, Outstanding Achievement).
23	6.3 Documentation for Accreditation	Self assessment, nature of reports, team feedback, facility feedback. Authoring. Version control.
<b>24</b>	<b>7. POLICIES ON DECISION MAKING</b>	
24	7.1 Accreditation Decision Making	Proper recording of decisions, authority for decisions, appeal process.
24	7.2 Determining Status of Training Organisation	Full accreditation. Provisional accreditation. Non accreditation. Withdrawal of accreditation. Duration of accredited positions / terms. Levels of posts e.g. PGY1. Number of trainees. Lapses in accreditation. Accreditation with conditions. Requirements for Primary Allocation Centres. Changed circumstances. When a review might be triggered.



## PRINCIPLES OF ACCREDITATION

### 1. INTRODUCTION

This document seeks to establish general principles that should underpin the accreditation process in the prevocational medical education and training domain.

#### 1.1 Definitions

**Principles** are general statements of intent to underpin the implementation of accreditation policies, processes and procedures.

**They are differentiated from policies and processes as follows:**

**Policies** are rules which must be adhered to in regard to the Accreditation Process.

**Processes** are systems for multiple stakeholders to follow at differing stages in the Accreditation Process.

#### 1.2 AIMS OF ACCREDITATION

The accreditation program administered by Postgraduate Medical Councils (or their equivalent) aims to:

1.2.1 Accredit Networks, Facilities, Units and Practices providing prevocational medical education and training.

1.2.2 Ensure support and development of education and training for all prevocational doctors to enable them to meet high standards of safe practice, clinical skills and professional confidence, and become eligible for full registration with the Medical Boards.

1.2.3 Ensure that the best possible environment exists to develop, evaluate and maintain the organisational processes that ensure excellence in the training of Prevocational Doctors.

1.2.4 Provide a common denominator of shared values and practices among the diverse health care settings which train Prevocational Doctors, in order to encourage communication and sharing of experiences<sup>1</sup>.

1.2.5 Promote links between the educational processes occurring at the medical school and vocational levels.

1.2.6 Provide the community with a process of external validation of prevocational education programs <sup>2</sup>.

1.2.7 Provide assistance to facilities by identifying for them, the strengths and weaknesses of their prevocational education programs <sup>2</sup>.

1.2.8 Provide a mechanism to empower educators to enhance their programs and provide incentives for quality improvement activities <sup>1</sup>.

### **1.3 CONTEXT OF ACCREDITATION**

Any prevocational accreditation arrangement must account for the context in which prevocational training occurs. In the development of PMAF, the following have been taken into account:

1.3.1 The need to develop national accreditation processes for prevocational medical education and training. In this regard, there is a need to take cognisance of existing processes in undergraduate and vocational medical training.

1.3.2 The recognition that standards for vocational trainees are developed by Medical Colleges.

1.3.3 That continuous achievement of training standards is balanced against demands on individuals and organisations seeking accreditation.

1.3.4 The need to develop standards for training facilities, and where, applicable for training networks and consortia (as applicable).

1.3.5 The need to recognise that accreditation practices should reflect current trends of exploring new training opportunities in private, community and rural settings to address increased medical graduate numbers.

### **1.4 SCOPE OF ACCREDITATION**

Currently the focus of most PMCs (or their equivalents) accreditation is on pre-registration doctors. Prevocational doctors include pre-registration doctors and those in non vocational training positions.

1.4.1 It is expected that all prevocational medical training in any setting be accredited by 2013.

1.4.2 At this stage the accreditation will not extend to cover Career Medical Officers (CMOs).

- a. A CMO is defined as a doctor employed or appointed to a position not being that of a doctor in training.
- b. Many of these have a continuing contract of employment.

## **2. PRINCIPLES OF ACCREDITATION**

### **2.1 General Principles**

Accreditation of prevocational training will have the following underlying general principles:

2.1.1 Safe and high quality patient care will be the primary consideration in any accreditation policy and processes

2.1.2 Accreditation will be based on a quality improvement framework using an educative approach.

2.1.3 Accreditation will be based on valid and reliable processes

2.1.4 Accreditation policies and processes will be explicit and transparent to all stakeholders <sup>1</sup>

2.1.5 Accreditation policies and processes will be robust, rigorous, efficient and equitable <sup>3</sup>

2.1.6 Accreditation policies and processes will be designed such that they should minimise the accreditation burden and where possible, co-ordinate with other accreditation processes and use shared documentation and data sets<sup>3</sup>

2.1.7 Accreditation policies and processes will be consistent with local and international best practice

2.1.8 Accreditation policies and processes will operate within the legal systems of the relevant states and territories

2.1.9 Accreditation bodies will have the requisite authority to undertake all aspects of prevocational accreditation processes

2.1.10 Accreditation policies and processes will promote a standard of excellence beyond the minimum level of compliance <sup>1</sup>

2.1.11 Accreditation bodies will have independence to provide assurance of the quality of sites and posts available for training and education of Prevocational Doctors

2.1.12 Trainees from “non-traditional backgrounds” (e.g. IMGs) should be informally assessed and then enter the prevocational workforce at a level appropriate to their educational and professional attainments, and to their cultural background.

### **2.2 Process Principles**

The processes involved in all accreditation systems for prevocational training will:

2.2.1 .Enable pre-registration doctors to progress to full registration in accordance with the legislation of the Medical Boards including an appropriate balance of terms.

2.2.2 Support quality education and training for all Prevocational Doctors.

2.2.3 Be monitored by an appropriately constituted Committee with representation from the range of groups involved in prevocational medical education and training including Prevocational Doctors.

2.2.4 Be based on accreditation standards which are explicit, clearly enunciated, defensible and practical. The standards will, where possible:

- a. use objective criteria, and process and outcome indicators, which relate closely to the goals of accreditation.
- b. encourage the use of tools for quality improvement e.g. self assessment against the published standards before an accreditation visit.
- c. be specific, yet applicable across a range of settings e.g. hospital-based training, general practice settings, community placements, and others.
- d. acknowledge that medical education programs are continually developing<sup>2</sup>.
- e. encourage innovation in the design and delivery of medical education programs<sup>2</sup>.
- f. recognise diversity of accreditation practices.

2.2.5 Have a predetermined quality cycle with clearly outlined stages that support ongoing improvement in outcomes. The quality cycle must include planning, monitoring, assessment, action, evaluation and feedback. There is an expectation that site visits will be part of this process.

2.2.6 Be regularly evaluated by the PMCs (or equivalent) in consultation with key stakeholder groups. Feedback from the evaluation process should be communicated appropriately to all key stakeholders.

2.2.7 Include a process to obtain ongoing feedback from Prevocational Doctors regarding their clinical education and training.

2.2.8 Be supported by an appropriate educational infrastructure with the required administrative support to enable effective delivery and evaluation of programs.

2.2.9 Provide appropriate sanctions for failure to meet accreditation standards if, despite opportunities for remediation and improvement, accreditation standards have not been met.

2.2.10 Have an appropriate appeal mechanism.

2.2.11 Be concordant with other national bodies and national initiatives for prevocational training such as the *Australian Curriculum Framework for Junior Doctors*.

2.2.12 Be provided with dedicated budgets that will include funding for all aspects of the accreditation process.

### **3. STANDARDS OF ACCREDITATION**

Appropriate and adequate clinical exposure is crucial to the success of prevocational training. The accreditation standards relating to training and education programs in all contexts\* are designed to encourage and support continuous improvement of prevocational training. The standards for any education and training program include:

#### **3.1 Governance Standards**

Governance, organisation and administration of the training and education programs include:

3.1.1 An organisational structure with appropriately qualified staff and educational support personnel to manage education and training programs, and provide the physical and infrastructure sufficient to meet the objectives of the programs.

3.1.2 Compliance with state or territory and national rules for prevocational training.

3.1.3 Equity of access for each Prevocational Doctor to training programs best suited for individual educational needs should be provided.

3.1.4 Policies, processes and procedures in place for ongoing evaluation of the training program. This should include evaluation by prevocational trainees of their programs and supervisors with provision of advocacy for Prevocational Doctors by those overseeing programs and supervisors.

3.1.5 Performance appraisal of all personnel involved in the training program with evaluation of teaching performance where appropriate.

3.1.6 Strategic planning and dedicated budgets to support current and future needs of the training and education program.

3.1.7 Systematic communication between practices, facilities and units to optimise education and training programs.

3.1.8 Development of documented processes to manage issues relating to workload, welfare, safety and managing substandard performance.

3.1.9 Establishment of an oversight committee to ensure that the policies for postgraduate training exist and is resourced and empowered.

3.1.10 Provision of appropriate clinical and non-clinical educational opportunities as appropriate for the group.

### **3.2 Prevocational Training and Education Program Standards**

Training and education programs have the following features:

3.2.1 Clinical exposure, structure and content that is relevant and mapped to the *Australian Curriculum Framework for Junior Doctors* as applicable to the particular training program.

3.2.2 Clear learning objectives.

3.2.3 An orientation, including an assessment to ensure that trainees have the requisite skills to commence the program.

3.2.4 Supervision by qualified medical staff with appropriate skills, knowledge, authority, competencies, time and resources to participate in training or orientation programs.

3.2.5 Professional development activities to provide qualified medical staff involved in the training program with opportunities to support the quality and development of the training programs.

3.2.6 Assessment of trainees ensuring that assessment processes are applied equally to all Prevocational Doctors and that evaluation data is collected, interpreted and used to feed back into the training programs for continuous improvement.

\* The standards relate to the various contexts available for prevocational training i.e. within units, facilities, practices and networks.

## **4. CONTINUITY**

### **4.1 Sustainability**

A prevocational accreditation system must have:

4.1.1 Mutual recognition, respect and trust of key stakeholders in medical education and training, maintained by setting defined standards for integrity, fairness, validity and reliability.

4.1.2 Be adequately resourced in terms of personnel, finance and infrastructure.

4.1.3 Efficiency in utilisation of resources.

4.1.4 A degree of continuity that promotes a capacity for evolution and continuous improvement.

4.1.5 Allowance for diversity within states and territories.

## REFERENCES

1. World Federation for Medical Education (WFME). Basic Medical Education. WFME Global Standards for Quality Improvement. (2003). University of Copenhagen; Denmark.
2. Harlen, J and Marel, G. (1999). CPMEC Uniformity of Accreditation.
3. Australian Medical Council (2002). Accreditation of Specialist Medical Education and Training Professional Development Programs: Standards and Procedures.

This document is based on information contained in the Postgraduate Medical Council of Queensland (2007). Principles of Accreditation:

- Accreditation Evaluation Process
- Accreditation Policy
- Accreditation Standards
- Full Survey Accreditation Process
- Modified Unit Survey Process
- New Surveyor Selection Process
- New Unit Survey Process
- Notification of Change of Circumstance That May Affect Accreditation Status Process
- Supervision Policy for Interns in Accredited Facilities
- Surveyor Conflict of Interest Policy
- Surveyor Policy



## **POLICIES**

This document seeks to establish policies that underpin Accreditation Practices in the prevocational medical education and training domain.

**Policies** are rules which must be adhered to in regard to the Accreditation Practices.

**They are differentiated from principles and processes as follows:**

**Principles** are general statements of intent to underpin the implementation of Accreditation policies, processes and procedures.

**Processes** are systems for multiple stakeholders to follow at differing stages in the Accreditation Process.

## **5. SYSTEM OVERSIGHT and GOVERNANCE POLICIES**

### **5.1 Resourcing and Funding of the Accreditation System**

5.1.1 Postgraduate Medical Councils (PMC; or their equivalent) will establish an Accreditation Committee and will provide the infrastructure and administrative support to:

- a. Develop policies, processes and procedures for Accreditation
- b. Enable the Accreditation Committee to attract and train qualified Surveyors
- c. Monitor the Accreditation status of Facilities and/or Networks
- d. Organise Accreditation visits by Survey Teams that use formal Accreditation Processes
- e. Provide independent Accreditation Reports to the PMC or equivalent: and relevant regulatory body

5.1.2 The PMC or equivalent will have funding policy to cover the cost of the Accreditation Process as outlined in 5.1.1.

- a. during an Accreditation Site Visit the Facility or Network will provide administrative and infrastructure support to the Survey Team
- b. if the Facility or Network does not provide required information or documentation within the timeframe required for a Accreditation Process, the facility will bear the cost of rescheduling the Accreditation Process
- c. the PMC or equivalent will ensure that any fees and charges for Accreditation Processes (where applicable) are fair and reasonable.

## **5.2 Scope of Accreditation**

5.2.1 The Accreditation Process may be applied to a Network, Facility or individual Unit. The Accreditation Survey process will cover:

- a. the nature and type of all individual prevocational training positions within the Facility or Network
- b. the organisation of the Education and Training program
- c. the standards of assessment within the Education and Training program
- d. the orientation of Prevocational Doctors within the Facility or Network, and within the Education and Training program
- e. the provision of appropriate clinical and non-clinical educational opportunities as appropriate for the individual Prevocational Doctor
- f. the resources which support pre-vocational education and training

5.2.2 Accreditation Surveys will follow the relevant Accreditation Processes. Accreditation Surveys may be by Site Visit or Paper Based. Accreditation Processes should include:

- a. Full Survey Process: First year of Accreditation Cycle for a Facility or Network or, as a component of the Process for Change of Status or, first time Accreditation (Site Visit Based)
- b. New Unit Survey Process: Accreditation of new Units that have not previously been Accredited within an Accredited Facility or Network (Site Visit or Paper Based)
- c. Modified Unit Survey Process: Accreditation for Units that are Accredited but are proposed to be modified (Site Visit or Paper Based)
- d. Periodic Survey Process: where the frequency of the survey is greater than 3 years, there should be a Mid-Accreditation Cycle Survey of Training and Education Programs (Paper Based)
- e. Other Survey processes as needed, pursuant to individual accreditation.

### **5.3 Application and Reapplication for Accreditation**

5.3.1 The Accreditation cycle is for a period of up to four years:

- a. The Facility or Network Manager applies for re-Accreditation, or PMC or equivalent notifies a Facility or Network of the requirement for a re-Accreditation Survey (Full Survey), in line with its current Accreditation Cycle.

5.3.2 Application for Accreditation must be made as part of the process for Change of Status (e.g.. change of secondment status to primary allocation status):

- a. Change of Status Applications will require a comprehensive survey process.

5.3.3 Application for Accreditation must be made for new Units within an Accredited Facility or Network.

- a. New Unit Applications will usually require a Full Survey Unit visit except as detailed under the specific provisions of *PMAF Policy 6.1.5*.

5.3.4 A Facility or Network must advise PMC or equivalent of a change in the governance, educational or support structures for prevocational doctors.

- a. Changes that disadvantage the training of prevocational doctors could result in a change of the accreditation status of the facility or network.

5.3.5 A Facility or Network must advise PMC or equivalent of a change in the unit which would affect education training of their prevocational doctors. In such event, an application for Accreditation must be made for such Units.

Examples of modifications which would require review include, but are not limited to:

- a. A link with another unit which impacts on the type and amount of clinical experience
- b. Change in supervision
- c. Alteration to clinical duties and/or rostering which would impact the exposure to the continuum of care and/or supervision
- d. Change in caseload e.g. additional VMO appointed (not seasonal variations in caseload)
- e. Change in number of prevocational doctors
- f. A currently Accredited unit now wanting to split into two separate units
- g. Relocation to another campus of the Facility.

## **5.4 Assessment Process and Feedback to Stakeholders**

5.4.1 The Survey process will assess the Education and Training program incorporating input from clinical supervisors, clinicians, administrators, and Prevocational Doctors. The process will:

- a. be constructive and collegial
- b. elicit both structured and documented feedback
- c. create a climate conducive to the collection of accurate information

5.4.2 The Survey Team Leader will meet with relevant staff from the Facility or Network at the conclusion of a Survey Visit. The aim of this is to review major issues which are likely to appear in the Accreditation Report.

5.4.3 The Accreditation Report will be written by the Survey Team Leader in consultation with members of the Survey Team

5.4.4 In all Accreditation Processes, documented feedback is received from, and disseminated, as appropriate, to:

- a. The Network or Facility staff involved in the Survey Process
- b. Prevocational Doctors engaged in the Education and Training program
- c. The Survey Team leader and the Surveyors
- d. The PMC or equivalent

## **5.5 Conflicts of Interest**

5.5.1 To ensure transparency in accreditation practices, each PMC or equivalent will have a documented *Procedure for Identifying a Conflict of Interest* to assist Surveyors and Facilities or Networks in identifying Conflicts of Interest in the Accreditation Process.

5.5.2 A Surveyor must declare any Conflict of Interest and may decline to participate in a Survey. Surveyors who believe that they may have a Conflict of Interest must seek advice from the Accreditation Committee. A perceived or potential Conflict of Interest may exist where the Surveyor:

- a. is currently employed by a Facility or Network within the same district as the Facility or Network being Accredited
- b. has been employed by a Facility or Network within the same district as the Facility or Network being Accredited, within the past two years, in any role that influences the Accreditation Process

- c. has a significant relationship (e.g. spouse, partner etc) with a person either directly involved in Training and Education Programs for Prevocational Doctors, or a stakeholder with an interest in the Accreditation at the Facility or Network being Accredited
- d. as any other reason/s that may suggest a Conflict of Interest.

5.5.3 The Facility or Network being Accredited has the right to formally object to the inclusion of a Surveyor on the Survey Team where they consider any of the conditions in section 5.4.2 apply.

5.5.4 The PMC or equivalent can identify potential Conflicts of Interest and can refer the matter to the Accreditation Committee for consideration.

## **5.6 Confidentiality**

5.6.1 The Accreditation Committee will obtain explicit Confidentiality Agreements from Surveyors and staff involved in Accreditation Processes.

5.6.2 PMC will define the limits of the confidentiality policy with respect to:

- a. personal information
- b. facility information
- c. breach of confidentiality policy
- d. scope of confidentiality

5.6.3 The PMC or equivalent will secure and store Accreditation documentation after any Accreditation Process. Documentation should be stored for at least 2 full Accreditation Cycles of the Facility or Network.

5.6.4 If the Facility or Network does not provide required information or documentation within the timeframe required for an Accreditation Process, the facility will bear the cost of rescheduling and completing the Accreditation Process

## **5.7 Appeals Policy**

5.7.1 The PMC or equivalent is required to develop a formal *Appeals Policy and Process*.

5.7.2 An organisation that is subject of a decision of the Accreditation Committee may appeal within 28 days of receipt of written advice of that decision.

5.7.3 Appeals to review Accreditation Decisions are lodged with the Chair of the relevant PMC or equivalent to have the Accreditation Decision managed by an Appeals process.

5.7.4 Appeals may be lodged for any of the following reasons:

- a. An error in due process occurred in the formulation of the decision under review
- b. Relevant and significant information which was available to the Surveyors was not considered in the formulation of the decision under review
- c. The decision of the Accreditation Committee was inconsistent with the information provided to the Committee

5.7.5 The Appeals Committee will be established which will normally comprise:

- a. A Chair who is normally appointed by the PMC or equivalent. The Chair will not normally vote on decisions of the Appeals Committee.
- b. Members will include at least one:
  - Experienced Surveyor,
  - Person with a background in a facility or network similar to the organisation being accredited
  - Representative of Prevocational Doctors.
- c. A secretary to the Appeals Committee who has no advocacy or voting rights.

5.7.6 The Appeals Committee will be governed by the following policies:

- a. The Appeals Committee will not include any individual who was party to the formulation of the Accreditation Decision under review.
- b. The Appeals Committee must act according to the laws of natural justice and decide each Appeal on its merits.
- c. The Accreditation Committee will be bound to accept the advice of the Appeals Committee and will uphold or set aside the Accreditation Decision accordingly.
- d. The Appeals Committee Chair will have the final vote in the situation where the Appeals Committee Decision is tied.

5.7.7 In any appeal, the Appellant will bear the burden of proof to establish the grounds of the appeal.

5.7.8 The Appellant will retain its earlier Accreditation Status during the appeal process unless the PMC or equivalent determines that patient care or Prevocational Doctor safety could be comprised.

## **5.8 Transparency and Publication of Results of Accreditation**

5.8.1 The PMC or equivalent is ultimately responsible for the transparency and publication of the results of Accreditation. This may include:

- a. publication of Accreditation results on the PMC or equivalent internet site
- b. inclusion in the Annual Report of the PMC or equivalent

## **5.9 Surveyor Recruitment, Training and Management**

5.9.1 The Accreditation Committee will develop a Surveyor Policy and Selection Procedure that includes:

- a. Position descriptions for survey team members
- b. Surveyor Code of Conduct
- c. Surveyor Confidentiality Agreement

5.9.2 PMC will define the list of stakeholders that can participate and the roles that they will perform. Surveyors can be drawn from the following:

- a. Junior medical staff (intern through to registrar)
- b. Clinicians from public or private sector
- c. DCTs
- d. MEOs
- e. EDMS/DMS/Medical Superintendent
- f. Staff of PMC or equivalent
- g. Medical Services/Workforce Managers
- h. General Practitioners
- i. Retired Medical Practitioners
- j. Others with suitable experience

5.9.3 A *Surveyor Selection Process* must be completed.

- a. To be appointed as a Surveyor the applicant must agree to comply with the *Surveyor Position Description and Code of Conduct*.
- b. A *Surveyor Confidentiality Agreement* must be signed.

5.9.4 A Surveyor must undergo training prior to his/her first Survey, including:

- a. Orientation to PMC or equivalent policies and processes, and Surveyor Code of Conduct.
- b. Trainee surveyor for at least one Full Survey Visit

5.9.5 A Survey Team must consist of:

- a. At least three Surveyors for a Full Survey Visit, preferably including a clinician and a doctor in training
- b. At least two Surveyors for a Rural Hospital, General Practice or New Unit or Modified Unit Survey.

5.9.6 A Survey Team may be divided into Sub Teams to facilitate Accreditation:

- a. Where a Sub Team is formed, a Survey Sub Team Leader will be designated by the Survey Team Leader.

5.9.7 In order to maintain currency and status as a Surveyor, it is recommended that a Surveyor complete two Accreditation Surveys per annum. This requirement may be waived at the discretion of the Chair of the Accreditation Committee.

5.9.8 Every Accreditation Visit must have an appropriately trained Survey Team Leader. A Survey Team Leader must:

- a. Have completed at least three Full Survey Visits (which may include experience in another domain e.g. ACHS, AMC, Colleges or other PMC or equivalent etc)
- b. Be nominated by the Accreditation Committee
- c. Be from any of the Surveyor backgrounds listed in this Policy
- d. Complete at least one Survey as a Survey Team Leader per annum to maintain currency and status as Survey Team Leader

5.9.9 The Survey Team Leader is responsible for the following:

- a. Organisation of a Pre Survey Meeting with Surveyors to allocate roles and responsibilities
- b. Chairing the meeting with relevant staff from the Facility or Network at the conclusion of a Visit.

- c. Preparation of the draft Accreditation Report
- d. Collation and final editing of the Accreditation Report prior to submitting to PMC or equivalent.

5.9.10 The Accreditation Committee should have a process in place for identifying and developing future survey members and Team Leaders

## **5.10 Supervision**

5.10.1 Clinical skills must be assessed by direct observation and must be documented as appropriate.

5.10.2 Prevocational Doctors in training positions must be supervised at all times regardless of which shift they are working or the location of their workplace. This supervision must ensure a safe clinical environment for patients and a safe learning environment for the Prevocational Doctor. Criteria for supervision may include situations where:

- a. The Supervisor is physically present;
- b. The Supervisor is not physically present with the Prevocational Doctor, but can be immediately contacted and is available on site if required by the Prevocational Doctor

5.10.3 The supervisor should at least be in their third postgraduate year and hold full medical registration for supervision of PGY1 and PGY2 prevocational doctors. Full registration is interpreted as a person who has been formally appointed to a supervisory position.

5.10.4 The Facility Manager is responsible for ensuring that the appropriate level of supervision is provided in accordance with the supervision policy of PMC or equivalent. The Facility Manager is also responsible for ensuring that there is continuity of supervision during periods of leave of the Training Supervisor or Unit Supervisor.

5.10.5 Unit Supervisors must ensure that supervision of Prevocational Doctors:

- a. Is adequate at all times, to ensure safe patient care
- b. Meets the criteria specified in 5.10.2 and 5.10.3
- c. Provides a safe learning environment for the Prevocational Doctor

5.10.6 Unit Supervisors should be aware of the skills and experience and workloads of all Training Supervisors within their teams:

- a. If the Unit Supervisor is not present on site, supervision may be delegated by the Unit Supervisor to another suitably experienced practitioner on site.
- b. Unit Supervisors must ensure that Training Supervisors are aware of their responsibility to determine the appropriate proximity of supervision, by considering the clinical situation, and the knowledge and experience of the Prevocational Doctor.

## **5.11 Review of the Accreditation System**

5.11.1 An evaluation process is recommended after each Accreditation Survey. This process will seek feedback from:

- a. The Facility or Network commenting on the Survey Team and PMC or equivalent administration of the Accreditation Process;
- b. The Survey Team commenting on the Facility or Network and PMC or equivalent administration of the Accreditation Process, and;
- c. PMC or equivalent commenting on the Facility or Network and the Survey Team's compliance with Accreditation Processes.

5.11.2 A collated Feedback Report will be prepared and considered by the Accreditation Committee as soon as practical after the completed Accreditation Survey Process.

5.11.3 The Survey Team Leader should provide all the Surveyors in his/her Survey Team with feedback following a Survey Visit.

## **6. POLICIES on SURVEYS**

### **6.1 Reviews and Visits of Facilities**

6.1.1 The maximum duration of the Accreditation cycle will be determined by the PMC or equivalent, and will not exceed a period of four years.

6.1.2 A Full Survey is required prior to lapse of Accreditation, therefore a Full Survey must be undertaken in the calendar year that the Accreditation will lapse.

6.1.3 If the cycle is four years, a Periodic Survey is required for every Accredited Facility regardless of their status as a Primary Allocation or Secondment Facility.

- a. The Periodic Survey occurs as close as possible to two years following the Facility's past Full Survey.
- b. The Periodic Survey is usually a Paper Based Survey.

6.1.4 A Full Survey is recommended:

- a. In Year One of the Accreditation Cycle
- b. As a component of the Process for Change of Status e.g. Secondment Facility to Primary Allocation Facility.
- c. When a Facility or Network requests Accreditation for the first time.

6.1.5 A site visit may not always be required (i.e. a paper-based Survey may be used) for a New Unit in a currently Accredited Facility or Network if it:

- a. Is comprised of staff who have previously been supervising Prevocational Doctors in similar settings, or
- b. Has been created through rearranging staffing and patient case mix or extension of other already Accredited units, or
- c. Provides similar clinical cases and similar patient numbers to other already Accredited units.
- d. If in the opinion of the Accreditation Committee the unit meets the required standards.

## **6.2 Levels of Compliance to Accreditation Standards**

6.2.1 Levels of Compliance will employ a rating system similar to that used by the Australian Council on Healthcare Standards (ACHS). The suggested rating scale is:

Low achievement (LA) – awareness and knowledge of the standards but only fundamental systems in place

Some Achievement (SA) – implemented systems but little or no monitoring of outcomes against standards

Moderate Achievement (MA) – collection of outcome data from systems designed to implement standards, and evidence of improvements to systems

Extensive Achievement (EA) – evidence of innovation and implementation of best practice including sharing of practice at a state or national level.

Outstanding Achievement (OA) – considered leaders in the field relevant to the Criterion being assessed. There is evidence of benchmarking and comparing systems internally and/or externally.

6.2.2 Demonstration of most of the components recommended in Accreditation Standards would result in an achievement of a MA rating:

- a. The MA rating is the minimum accepted standard to achieve Accreditation.

### **6.3 Documentation for Accreditation**

6.3.1 At the time of Application for Accreditation the Network or Facility is advised of the documentation required by the PMC or equivalent.

- a. This documentation will be relevant to the context of Accreditation sought, i.e. Full Survey Accreditation, New Unit Accreditation, Modified Unit Accreditation or Periodic Survey.
- b. Where documentation is received outside the timelines as outlined in the relevant process, the PMC or equivalent may cancel the Survey Visit and rearrange another Visit, at a cost to the Facility or Network.

## **7. POLICIES on DECISION MAKING**

### **7.1 Accreditation Decision Making**

7.1.1 Facilities will be notified of Accreditation status following endorsement by the PMC or equivalent of the jurisdiction.

7.1.2 Outcomes of the Accreditation Decision making process may be:

- a) full accreditation for the cycle or
- b) conditional accreditation which may be of limited duration and or have specific provisos to be met.
- c) provisional accreditation which is awarded prior to the position being filled.

7.1.3 The decision as to whether a Unit is considered Modified or New will be made by the Chair of the Accreditation Committee.

## **7.2 Determining Status of Training Organisation**

7.2.1 All Education and Training Programs (and by extension all training positions) must be Accredited by the PMC or equivalent before a Prevocational Doctor is placed in the Network, Facility, Unit or Practice.

7.2.2 PMC or equivalent must maintain a database of Accredited units that describes the maximum number of Prevocational Doctors for which each Unit has been accredited.

- a. Prevocational Doctors must not be rostered to unaccredited units.
- b. Only Units that have been reviewed by the Survey Team during the Accreditation Visit are eligible for Accreditation.
- c. Allocation rosters of a Facility or Network must correspond to the database of Accredited Units, to allow easy cross-referencing by the Survey Team and by the PMC or equivalent.
- d. Individual Prevocational Doctor term allocations must accord with the policies and processes of the PMC or equivalent.
- e. Term allocations for PGY1 trainees must also fulfil the core requirements for medical board registration.

7.2.3 Accreditation will occur only if a Facility or Network complies with the Standards and Criteria as outlined in PMC or equivalent Accreditation Standards document.

7.2.4 The PMC or equivalent must be immediately notified when changes occur within any Network or Facility that could affect the Accreditation of the Network, Facility or Unit.

7.2.5 A Facility or Network may be accorded Primary Allocation Centre Status only if it has:

- a. the capability to deliver all of the Core Terms and all Non-core Terms within the Primary Allocation Centre and its Secondment Units..
- b. achieved a Level of Compliance (Policy 6.2) of Extensive Achievement (EA) or higher in each of the Core Terms and a minimum of Moderate Achievement (MA) in all Non-Core Terms.
- c. a range of terms sufficient to fulfil the requirements of the PMC or equivalent.

7.2.6 Accreditation of an individual Unit will be deemed to have lapsed if a Prevocational Doctor has not been placed in that Unit for a period of greater than two years since Accreditation was granted. Should this occur:

- a. the Unit will require review and re-Accreditation before a Prevocational Doctor is again placed in that Unit.

7.2.7 Where a potential breach of an Accreditation Standard is brought to the attention of PMC or equivalent at any point in the Accreditation cycle, the Accreditation Committee will review the information provided and determine what actions if any are required.

- a. Periods of reduced Accreditation can be awarded by the PMC or equivalent where non compliance with standards has been identified.

This document is based on information contained in the Postgraduate Medical Council of Queensland (2007). Principles of Accreditation:

- Accreditation Evaluation Process
- Accreditation Policy
- Appeals Policy
- Application for Change of Accreditation Status
- Facility Allocation Status Policy
- Modified Unit Survey Process
- New Surveyor Selection Process
- New Unit Survey Process
- Notification of Change of Circumstance That May Affect Accreditation Status Process
- Periodic Survey Process
- PMCQ Accreditation System Overview
- Report Writing Process
- Supervision Policy for Interns in Accredited Facilities
- Surveyor Conflict of Interest Policy
- Surveyor Policy



## GLOSSARY

**Accreditation** □ Accreditation is a process by which a PMC or equivalent evaluates a program against pre-determined Criteria or Standards (Cleary, 1995). In this context, it refers to the evaluation of Prevocational Education and Training Programs.

**Accreditation Committee** □ The Accreditation Committee of the PMC or equivalent deals with the policies, processes and procedures of Accreditation. In most cases, this Committee reviews Reports from Accreditation Survey Teams and makes recommendations to the State Medical Board on these Reports through the PMC or equivalent. The Committee is comprised of a variety of stakeholders as outlined in their Terms of Reference.

**Accreditation Cycle** – The Accreditation Cycle is a three or four year cycle of Accreditation Events. Following the initial Survey the next Full Survey occurs in the calendar year in which Accreditation will lapse.

**Accreditation Processes** □ The Accreditation Program is comprised of a number of Accreditation Processes that describe "what happens," and usually involves multiple stakeholders to complete at different stages within the Accreditation Process. A process includes a diagrammatic flowchart representation of each step within the Accreditation Process.

**Accreditation Program** □ The Accreditation Program is a framework of principles, policies, processes and procedures undertaken by PMC or equivalent, that occur over time, with the specific aim of establishing a Health Care Facility's ability to adequately and within a quality framework, implement the training of Prevocational Doctors and hence be bestowed Accreditation status on behalf of the State Medical Board.

**Accreditation Report** □ The Accreditation Report is the formal written document prepared by the Survey Team following an Accreditation Survey. It contains a written assessment of the Facility's compliance with the Standards and provides recommendations for quality improvements. This Report contains a recommendation regarding the level of Accreditation to be awarded.

**Appeal** – An Appeal is a request for review of recommendations made by a Survey Team that is endorsed by the Accreditation Committee, prior to the submission of the Report to the State Medical Board where relevant.

**Appeals Committee** – The Appeals Committee is the independent group convened by the Chair of the Postgraduate Medical Council Board (or equivalent), responsible for reviewing the accreditation recommendations regarding the Facility making the appeal.

**Change of Circumstance** – A Change of Circumstances refers to any circumstance which may result in the Facility no longer achieving the Accreditation Standards e.g. No DCT, no senior clinician available as Supervisor, closure of a ward causing change to caseload or casemix.

**DCT** – Directors of Clinical Training (DCTs) are currently practising medical practitioners appointed in each Facility to support the training of junior doctors. The DCT has a responsibility to assess the strengths and weaknesses in the Facility's Prevocational Education Program and to rectify or modify the program where needed. DCTs or Executive/ Directors of Medical Services (E/DMSs) are responsible for reporting on the assessment and suitability of PGY1 and AMC candidates on probationary registration for registration.

**District** – A District is a geographic area defined by the relevant state authority.

**EDMS** – The E/DMS is the medical practitioner who leads each Facility's medical administration.

**Evaluation** – Evaluation is the process whereby the educational program itself and the experience in each Unit, is appraised by those undertaking the program, and those implementing it. This should comprise several elements including structured and documented feedback from Prevocational Doctors themselves.

**Facility** □ The Facility is the institution or clinical setting within which Prevocational Trainees work and train. These organisations will usually be hospitals but may be health care centres or supervised practice locations in community settings which have met Accreditation requirements for Prevocational Training.

**Facility Manager** □ The Facility Manager is the person employed to accept ultimate responsibility for administration of all staff at the Facility. Health Facilities need to indicate the Facility Manager at the time of application for Accreditation.

**Intern** – A doctor registered by the State Medical Board as a general registrant with Internship conditions.

**Levels of Supervision** □ The following levels of Supervision have been defined to provide clarity of proximity of Supervisor to the Prevocational Doctor.

- a. **Level 1 (Direct) Supervision** – Direct Supervision is where the Supervisor is physically present with the Prevocational Doctor in the performance of his or her duties
- b. **Level 2 (In-Facility) Supervision** – In Facility Supervision is where the Supervisor is not physically present with the Prevocational Doctor, but is immediately available on site if required by the Prevocational Doctor, without impediment to access. The Supervisor must be aware of the duties being performed by the Prevocational Doctor.
- c. **Unsupervised** □ Unsupervised is where the Prevocational Doctor is unable to access appropriately qualified assistance or observation which is likely to lead to harm to a patient or the Prevocational Doctor.

**MEO** – The Medical Education Officer is an experienced educationalist employed to assist the DCT in developing educational processes and procedures supportive of the Training Program.

**Prevocational Doctor** Prevocational Doctors include pre-registration doctors and those in non vocational training positions.

**Primary Allocation Status** – Primary Allocation Status is the Accreditation Status awarded to a Facility capable of providing all the compulsory terms required for Prevocational Doctor registration.

**Registrar** – A registrar is a doctor who has been accepted into an accredited specialist training program in a clinical specialty with a nominated college.

**Secondment Allocation Status** – Secondment Allocation Status is the Accreditation Status awarded to a Facility with accredited terms, but which is unable to provide one or more of the compulsory terms required for Prevocational Doctor registration.

**Standard** □ A Standard is a statement which outlines the specifications, processes or procedures required for implementing Postgraduate Education and Training. The Standard is intended to ensure that a Facility consistently provides or strives to provide quality education to Prevocational Doctors and at a level deemed appropriate by the wider stakeholder group.

**Supervision** □ Direct or indirect monitoring of Prevocational Doctors by more senior medical staff, which should make sure that patients are safe and cared for, and that Prevocational Doctors acquire appropriate Knowledge, skills and attitudes in their professional development. In the context of Prevocational Doctor training, supervision also refers to the provision of training and feedback, to assist Interns to meet the training requirements to satisfy registration by the State Medical Board.

**Supervisor** □ A medical practitioner who is responsible for ensuring that the Prevocational Doctor is performing his or her duties safely and effectively, and for providing feedback and training in the course of the work of the

Prevocational Doctor. Given the complexity of the tasks performed by the Prevocational Doctor, supervision should be provided by a medical practitioner with unrestricted general registration with the State Medical Board and at least three years postgraduate clinical experience. A specialist opinion must always be available.

**Survey Sub Team Leader** – A Survey Sub Team Leader is an experienced Surveyor assigned to assist the Survey Team Coordinator by leading a Sub Team of the Survey Team. Each Survey Team consisting of four or more Surveyors will be divided into Sub Teams in order to conduct the Unit interviews at a Facility. The Survey Sub Team Leader is responsible for the tasks outlined in the relevant Position Description.

**Survey Team** □ A Survey Team is a group of Surveyors chosen for their individual expertise to undertake a Survey Visit of a Facility.

**Survey Team Coordinator** □ The Survey Team Coordinator is the specially trained leader of the Survey Team, ultimately responsible for the writing, collation, and review of the Accreditation Report to be presented to the PMC or equivalent Accreditation Committee.

**Surveyor** □ A Surveyor is an individual trained in all aspects of the Accreditation Program who acts on behalf of the PMC or equivalent to visit a Facility and assess its compliance with the Standards.

**Term (Compulsory)** □ A Compulsory Term is one which must be completed within the Postgraduate year as prescribed by the State Medical Board. There are three compulsory terms which are Medicine, Surgery and Emergency. Each compulsory term must be a minimum of 10 weeks and conducted within one placement.

**Term (Non Compulsory)** - A Non Compulsory Term is an accredited Prevocational Doctor placement of at least five weeks duration in a clinical area deemed appropriate.

**Term or Training Supervisor** – an appropriately qualified medical practitioner that acts as a Supervisor of Prevocational Doctors within an accredited unit, ensuring appropriate supervision throughout the term

**Unit Supervisor** □ a Senior Medical Officer, Consultant, or General Practitioner who is responsible for postgraduate medical education and training within an accredited unit, and who oversees the activities of term or training supervisors.

**Whistleblower** – A Whistleblower is the person/s who informs PMC or equivalent of the change of circumstance with the potential to impact on accreditation status.

## NOTES