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Application for accreditation as an approved practice setting

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Name of service:

Contact person (for questions about this application) ______________________________

Name

Postal address:

Street address:

Phone: **Fax:**

Email address:

Date submitted:

Names of doctors registered in a vocational scope working in service:
(may be attached as an appendix)

____________________ ____________________

____________________ ____________________

____________________ ____________________

We wish to apply for accreditation as an approved practice setting, for the purposes of employing or contracting the services of IMGs and providing supervision to them. If approved by the Medical Council, accreditation will be for a 3 year period from date of approval.

Chief Medical Officer:

____________________ ____________________
Name Signature

Clinical Director or Head of Department:

____________________ ____________________
Name Signature

Assessment for accreditation as an approved practice setting

Introduction

This document is designed to assist a service to become accredited by the Medical Council of New Zealand (Council) as an Approved Practice Setting (APS). If a service meets the requirements of an APS, this will satisfy Council that appropriate support and supervision is available and provided to IMGs to ensure their safe integration into medical practice in New Zealand, and ongoing assessment.

The assessment checklist is designed for both primary and secondary care. The following three publications are of direct relevance to this checklist and are available at www.mcnz.org.nz

- *Supervision for international medical graduates*.
- *Continuing professional development and recertification*.
- *Good Medical Practice.*

This application is a tool for the purposes of gathering information and Council will assess each application in its entirety, rather than on whether individual questions provide a satisfactory or unsatisfactory outcome to the application. There are no absolute correct or incorrect answers to questions in this application. The answers to questions will vary between services.

Section 1: Clinical governance

It is expected that all doctors, both senior and junior, have meaningful, appropriate input to the systems by which health care is delivered and the quality of that health care can be continually improved. There should be a formal system of clinical governance or a quality assurance system that includes clear lines of responsibility and accountability for the overall quality of medical practice.

1.1 Structures

1.1.1. Describe the structure that is used for both service and hospital-wide decision making on key clinical issues. Please provide evidence such as charts that demonstrate the organisation structure and the service clinical structure.

1.1.2. What clinical meetings and peer review meetings take place? Please provide the meeting schedule, including a description of content, evidence of attendance, and a sample of activities that have been reviewed.

1.1.3. Describe how the meetings are structured to ensure a focus on learning.

1.2 Quality and public safety

1.2.1 Both quality of care and public safety are key priorities for health care organisations and services. Demonstrate how your organisation/service states this concept and ensures that quality and patient safety is a priority.

1.2.2 Describe how employees of your service are informed and involved in quality and public safety.

1.3 Risk management

1.3.1 Describe the risk framework used by the organisation.

1.3.2 Describe the incident management system and the tools used in it. Do you undertake a root cause analysis? What methods are used that ensure that learning occurs in the organisation from incidents that happen?

1.3.3 Describe the support systems available for staff who are involved in adverse incidents or near misses.

1.3.4 Is there an evaluation of how well the support systems are working for staff involved in incidents or near misses?

1.4 Complaints system

1.4.1 What methods are in place to ensure that complaints are appropriately acted upon and relevant staff informed?

1.4.2 How does the organisation/service know that relevant changes have been made as a result of complaints? Do you have a method of evaluating what system changes take place and the effectiveness of these changes?

1.4.3 Is there a policy on 'full disclosure' and how does the organisation/service know that staff are aware of the policy and it is conscientiously actioned?

1.5 Identifying and acting on concerns

1.5.1 It is expected that the learning environment for IMGs is one in which they are continuously supported to improve performance. How does the organisation/service ensure that such an environment exists?

1.5.2 What support mechanisms are available for those who meet their responsibility to report concerns regarding fitness to practise (conduct, competence, or health)?

1.5.3 What policies and procedures are in place that are aimed at early identification and remediation of concerns over fitness to practise (conduct, competence, or health)?

Section 2: Clinical management of doctors

2.1 Annual appraisal process

2.1.1 Is there a method of giving and receiving performance feedback on an annual basis? Please describe. Does this include an appraisal of the supervision relationship?

2.2 Credentialling

2.2.1 Is there a process of credentialling employees on appointment, or a similar process for those entering general practice? Does it include annual review? Please provide your credentialling framework.

2.3 Induction

2.3.1 Please provide the framework for induction and orientation process, for both your organisation and your service. Please include details of how the NZ health system and cultural competence are covered.

2.4 Supervision and assessment

2.4.1 Each IMG is expected to maintain a portfolio that includes:

- a logbook of procedures undertaken (if appropriate)
- evidence of clinical audit and peer review activities
- documentation of educational activities

Please provide evidence that portfolios are reviewed at three monthly meetings between the supervisor and the IMG and that any educational needs are identified.

2.4.2 Describe how records are stored of complaints or incidents that involved the IMG, including any concerns raised by colleagues, and any other information relevant to fitness to practise (conduct, competence, or health).

2.4.3 Describe and provide evidence of a documented supervision framework.

2.4.4 Describe the process for dealing with supervision reports. Are supervision reports completed every three months for each IMG? Are reports discussed with the IMG? Who reviews all supervision reports? Where are they stored?

2.4.5 What is the process for dealing with an IMG's poor performance? What happens when there is a poor report?

2.4.6 How many doctors registered within the relevant vocational scope work in your service? Has this number changed over the past year? How do you ensure that they are aware of which doctors require supervision.

2.4.7 If your service spans more than one site, please describe how clinical staff are allocated to each site. Do they rotate through all sites? How many doctors registered within the relevant vocational scope at each site? How do you ensure the IMG is appropriately supervised at all times?

2.4.8 Please describe the learning resources available, such as internet access to medical web sites, library etc.

Section 3: Adherence to regulatory requirements

3.1 Practising certificates (PC)

3.1.1 What processes are in place that enables the organisation to ensure that all medical staff hold a current practising certificate?

3.1.2 How do you ensure that all medical staff are working within any conditions on their practising certificate?

3.1.3 How does the organisation/service know that the medical staff are aware of their obligations as described by *Good Medical Practice*