



Policy on accreditation of an approved practice setting

Policy Statement

Any service accredited by Council as an approved practice setting (APS), must demonstrate 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.

To be recognised and accredited an APS will provide evidence that there are systems to support the following:

- 1 The effective clinical management of doctors that includes:
 - An annual appraisal or assessment process for individual doctors, based on the principles of *Good Medical Practice*.
 - Processes for credentialling (or alternative appropriate process in general practice) for IMGs on appointment, with annual review.
 - Documented induction and orientation processes for IMGs that meet Council's best practice guidelines. This will include a formal mandatory programme, including cultural competence, the Treaty of Waitangi, and an understanding of the New Zealand health system.
 - A documented framework for the supervision of IMGs that meets the requirements outlined in Council's booklet *Supervision for international medical graduates*. An APS requires a service to have a minimum of two doctors registered in the same vocational scope as the IMG. If the service spans two or more sites, by either a network or joint service arrangement, then evidence of the extent to which the IMG will be working with other doctors registered in the same vocational scope and how this will occur will need to be provided.
 - Portfolios for each IMG that will include:
 - a logbook of procedures performed (for procedural specialties)
 - evidence of clinical audit and peer review activities
 - documentation of training and educational activities
 - supervision reports
 - information about complaints or incidents relevant to fitness to practise, including any concerns raised by colleagues
 - other relevant papers or correspondence.
 - The provision of relevant training or continuing

professional development, that is based on identified educational needs, so that doctors have access to and participate in activities to update the knowledge and skills relevant to their professional work.

- Providing a learning environment for the IMG, for example access to the internet and relevant literature.

2 A system of clinical governance or a quality assurance system that includes clear lines of responsibility and accountability for the overall quality of medical practice that includes the below.

- A formal structure that is supported and used for service or hospital-wide decision making on key clinical issues including evidence of:
 - an organisational structure that supports clinical governance
 - meetings occurring with content on clinical matters
 - structured and regular peer review/case review processes that focus on learning, with evidence of attendance and submissions to review.
- Evidence that quality and patient safety is a priority for the service or organisation.
- Clear policies aimed at managing risks evidenced by:
 - a risk framework in the service or organisation
 - a formal incident management system in place which utilises tools such as root cause analysis, and that include methods of improving the processes and systems that have contributed to the incident
 - evidence of support for staff involved in any incidents or near misses that provide a learning opportunity.
- Acting on and learning from complaints that includes:
 - a formal consumer complaints policy, and process, with evidence of feedback to staff
 - evidence of full disclosure to patient(s) and family members as appropriate.
- Identifying and acting on concerns about doctors' fitness to practise that include:
 - procedures to support the individual to improve their performance whenever possible
 - support for doctors in their duty to report any concerns about colleagues' fitness to practise (including conduct, health or performance)
 - clear procedures for reporting concerns so that early action can be taken to avoid harm to patients and remedy problems.

3 Providing regulatory assurance that all employed or contracted doctors are registered with the Medical Council of New Zealand, hold a current practising certificate, are

working within any conditions of their practising certificate and are both required and enabled to abide by *Good Medical Practice*.

Procedures

- Accreditation of an APS will take place through a paper audit using a self assessment checklist.
- Self assessment will also be used as the usual method for ongoing assessment at regular intervals.
- Assessment will usually take place at intervals of 3 years.
- Feedback to Council from IMGs will form part of the audit. The feedback from IMGs will be provided directly to Council and anonymised prior to Council considering it and deciding whether to provide feedback to the service. In the circumstances of small services, consideration will be given as to how this will be done to ensure the integrity of the feedback.
- Council will reserve the right to visit any service to undertake an audit, or to initiate a paper based audit at any stage, to review compliance with the criteria. An audit may be initiated at anytime including but not limited to:
 - Non-compliance with the paper based audits.
 - Concerns raised through various channels.
 - Discrepancies between practice and reality in the service/practice.
 - A change to the onsite staffing level that reduces the number of doctors registered in the same vocational scope to less than two in the service or practice.
 - Complaints from IMGs.
- Should Council resolve to decline an application for accreditation as an APS, Council will provide reasons for its decision. A service may re-submit an application at anytime, however the reasons Council has provided must be addressed.

Note

Council does not intend to duplicate any existing processes and will therefore recognise existing accreditation status with another body for example:

- Quality Health New Zealand.
- International Accreditation New Zealand.
- RNZCGP CORNERSTONE General Practice Accreditation Programme.

If a service holds accreditation status with an alternative body recognised by Council, then only those criteria that Council has set for recognition as an APS that are over and above those in the existing accreditation processes will need to be met.

Approved by Council:

13 April 2010