



**Te Kaunihera Rata  
o Aotearoa**

Medical Council  
of New Zealand

# Accreditation standards for prevocational medical training of doctors in Aotearoa New Zealand

## Introduction

### Purpose and scope of prevocational medical training

This document sets out the standards against which prevocational medical training programmes are accredited by Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand (Council).

Prevocational medical training (the intern training programme) comprises the two years following registration with the Council and includes postgraduate year 1 (PGY1) and postgraduate year 2 (PGY2). Prevocational medical training must be completed by all graduates of Aotearoa New Zealand and Australian accredited medical schools as well as doctors who are registered via the Examinations pathway, (including those who have passed the New Zealand Registration Examination (NZREX Clinical) or another recognised clinical examination). Doctors undertaking this training are referred to as interns.

### Aim and educational approach of intern training programmes

The aim of an intern training programme is to ensure that interns further develop their clinical and professional skills to ensure they practice safely and competently. The programme is based on adult learning principles and has at its core a personally-developed professional development plan (PDP).

### Accreditation framework and accountability

Accreditation encourages self-examination and continuous improvement; it is based around peer review and has both a quality assurance and a quality improvement focus.

To be effective for this purpose:

- accountability must align with decision making authority
- there must be executive / leadership commitment
- information must be triangulated to see how policies are translated into the day-to-day experiences of supervisors and trainees.

The standards that are laid out in this document identify and assign accountability at a:

- national level (the [training organisation](#))
- regional level (the [training region](#))
- district level (the [district training provider](#)).

The [training organisation](#) is accredited on standards related to high-level oversight, governance, support, and strategic direction which is implemented by the district training providers.

The [training region](#) is accredited on standards related to resourcing and strategic matters.

The [district training provider](#) is accredited for the purpose of providing prevocational medical training. The district training provider must ensure that there are appropriate accredited clinical attachments that provide quality training, supervision and assessment that enable interns to gain a breadth of experience and to achieve the learning outcomes outlined in the 14 learning activities of the curriculum, as well as providing a teaching programme. Clinical attachments will only be accredited if they form part of the intern

training programme provided by an accredited district training provider. Clinical attachments take place in a variety of health care settings, including hospitals and community-based settings.

Council will accredit training programme for the purpose of providing prevocational medical education and training through the delivery of an intern training programme to those who have:

- structures and systems to ensure interns have sufficient opportunities to achieve the curriculum learning outcomes and complete PGY1 and PGY2 requirements
- an integrated system of education, supervision, and support, and
- accredited clinical attachments that deliver high-quality education and a broad clinical experience.

The standards for accreditation identify the basic elements that must exist in all accredited intern training programmes while allowing flexibility in the ways in which the training organisation, training regions and district training providers can demonstrate they meet the accreditation standards.

# TRAINING ORGANISATION

## 1. Strategic priorities, accountability, and policy

### Standard 1.1: Strategic priorities

#### 1.1.1

The training **organisation** has key strategic priorities which include development and support of high quality prevocational medical education and training.

#### 1.1.2

The training **organisation's** strategic priorities address Māori health and health equity.

#### 1.1 – Notes – Strategic priorities

(i) *As the training organisation, Health New Zealand is responsible for setting an organisational commitment and strategic priorities for high standards of prevocational medical training, that address Māori health and health equity. This commitment and prioritisation should be demonstrated in what the organisation does, more so than in what it formally documents. Potential ways to demonstrate this include through governance, leadership responsibilities and decision-making, delegations, performance and accountability frameworks, resourcing, systems and procedures, public statements, professional development frameworks, and shown through the organisation's culture.*

### Standard 1.2: Accountability

#### 1.2.1

The chief executive, or their delegate, has executive accountability, and the national chief medical officer, or their delegate, has clinical accountability, for the oversight of prevocational medical training.

#### 1.2.2

The training **organisation** resources training regions sufficiently, for the purpose of prevocational medical training.

#### 1.2.3

The training **organisation** ensures that staff involved in prevocational medical training can access professional development activities to support their teaching and educational practice.

#### 1.2.4

The training **organisation** has processes to manage matters escalated to organisational leadership from the training region and district training provider levels.

## Standard 1.3: Liaison with the Council

### 1.3.1

There is a process to address any matters raised by the Council in relation to training oversight, including:

- matters arising from district provider site accreditation visits
- district training provider or training region issues escalated to the training **organisation**.

### 1.3.2

The training **organisation** reports, to the Council, any changes that may significantly impact the delivery of prevocational training at the training region and/or district training provider level, as they are planned or occur.

#### *1.3 – Notes – Liaison with the Council*

- (i) An annual report template will be provided to the training organisation. The training organisation will be asked to provide a summary detailing significant developments since the last annual report and any specific issues that may affect the training organisation's ability to continue to meet specific accreditation standards.*

## Standard 1.4: Policy

### 1.4.1

The training **organisation** has policies on the following:

- adhering to the Council's statement on obtaining informed consent
- flexible training
- additional cultural obligations
- discrimination, bullying, and harassment
- review and resolution of intern training-related disputes
- professional development leave for interns.

### 1.4.2

The training **organisation's** policy on professional development requires staff involved in intern training to undertake professional development activities to support and develop their teaching and educational practice.

# TRAINING REGION

## 1. Accountability and resourcing

### Standard 1.1: Accountability

#### 1.1.1

The executive regional director, or their delegate, has executive accountability, and the regional chief medical officer, or their delegate, has clinical responsibility, for:

- meeting prevocational accreditation standards at the training **region** level
- ensuring that a structure exists to support prevocational medical training standards being met at district training provider level.

#### 1.1.2

There is **regional** oversight and facilitation of relationships with external organisations involved in training and education.

#### 1.1.3

The training **region** has clear lines of reporting and escalation processes from the training provider level through to those responsible at the training region and training organisation level.

#### 1.1.4

If a training region, or two or more district training providers within a training region, assume responsibility for meeting district training provider-level standards, they must notify the Council and provide a formal agreement about accountability for those standards.

#### 1.1 – Notes – Accountability

- Effective working relationships should be formed with other organisations and networks including the Council, medical schools, medical colleges, primary health organisations, other health service localities, Māori health sector representatives and community-based healthcare providers.*
- Where districts are sharing services or are part of a network programme, that is a matter for them and their region, and this needs to be specified in formal documentation stating who is accountable. Accreditation and monitoring processes will remain at a district level however in such cases those responsible at a region or sub-region level would contribute to the self-assessment, site visits and monitoring reports.*

### Standard 1.2: Resourcing

#### 1.2.1

The training **region** resources district training providers sufficiently, to provide prevocational medical training.

#### 1.2.2

The training **region** ensures that staff involved in prevocational medical training have adequate time to undertake their responsibilities for training and supervising interns.

### 1.2 Notes – Resourcing

(i) *Resourcing should include, but are not limited to:*

- *appropriate medical education expertise*
- *appointing additional prevocational educational supervisors as needed*
- *sufficient administrative support to plan, develop, implement, and review the intern training programme*
- *sufficient administrative support for prevocational educational supervisors and directors of clinical education (or equivalent) to adequately undertake their roles*
- *the provision of cultural safety resources and training*
- *establishing and implementing community-based attachments*
- *facilities and infrastructure.*

## Standard 1.3: Liaison with the Council

### 1.3.1

There is a process to address any matters raised by the Council in relation to training oversight, including:

- matters arising from district provider site accreditation visits.
- district training provider issues escalated to the training **region**.

### 1.3.2

The training **region** reports, to the Council, any changes that may significantly impact the delivery of training programmes as they planned or occur.

### 1.3 – Notes – Liaison with the Council

(i) *An annual report template will be provided to the training region. The training region will be asked to provide a summary under each major accreditation standard detailing significant developments since the last annual report and any specific issues that may affect the training region's ability to continue to meet specific accreditation standards.*

# DISTRICT TRAINING PROVIDER

## 1. Strategic planning and governance

### Standard 1.1: Strategic planning

#### 1.1.1

The **district training provider** has a strategic plan for ongoing development and support of high quality prevocational medical training and education, which reflects the training organisation's strategic priorities.

#### 1.1.2

The **district training provider** addresses Māori health and health equity as part of its commitment to high quality prevocational education and training.

### Standard 1.2: Governance

#### 1.2.1

There are clinical governance and quality assurance processes that ensure clear lines of responsibility and accountability for intern training in the overall context of quality medical practice.

#### 1.2.2

There is formal intern representation in the governance of the prevocational medical training programme.

#### 1 – Notes – Strategic planning and governance

- (i) *The district training provider can demonstrate recognition and appropriate resourcing for teaching, training, appraising, and assessing doctors which is critical in the development of a highly skilled workforce to support quality of patient care.*
- (ii) *The district training provider will have its own governance and administrative group responsible for the development, review and ratification of policies and processes that relate to the intern training programme.*

## 2. Organisational and operational structures

### Standard 2.1: The context of intern training

#### 2.1.1

The **district training provider** demonstrates that it has the mechanisms in place to plan, develop, implement, and review the prevocational training programme.

#### 2.1.2

The chief medical officer (CMO) or their delegate (for example a director of clinical training) has executive accountability for meeting prevocational education and training standards and for the quality of training and education at the **district training provider** level.

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### 2.1.3

There are effective organisational and operational structures to manage interns.

#### 2.1 – Notes – The context of intern training

- (i) *Effective organisational and operational structures include utilising resources within the prevocational district training provider, for example the Māori health team (or equivalent) and other allied education and training resources.*

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## Standard 2.2: Liaison with the Council

### 2.2.1

There are clear procedures to notify the Council of changes in a health service or the intern training programme, as they are planned or occur, that may have a significant effect on intern training.

### 2.2.2

There is a process to address any matters raised by the Council in relation to training, including those arising from accreditation visits.

#### 2.2 – Notes – Liaison with the Council

- (i) *An annual report template will be provided to the district training provider. The district training provider will be asked to provide a summary under each major accreditation standard detailing significant developments since the last annual report and any specific issues that may affect the district training provider's ability to continue to meet specific accreditation standards.*

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## Standard 2.3: Educational expertise

### 2.3.1

The **district training provider** demonstrates that the intern training programme is underpinned by sound medical educational principles.

### 2.3.2

The **district training provider** has appropriate medical educational expertise in place to deliver the intern training programme.

#### 2.3 – Notes – Educational expertise

- (i) *The education principles underpinning the intern training programme must include an understanding of the teaching, learning practices and assessment methods in medical education and clinical supervision.*
- (ii) *District training providers are encouraged to form links and partnerships with medical schools, other prevocational district training providers and medical colleges to access additional educational expertise to support the intern training programme.*
- (iii) *District training providers must have appropriately qualified staff, to meet the objectives of the intern training programme.*

## Standard 2.4: Relationships to support medical education

### 2.4.1

There are effective working relationships with external organisations involved in training and education.

### 2.4.2

The **district training provider** coordinates the local delivery of the intern training programme or collaborates in such coordination when it is part of a network programme.

### 2.4.3

There are effective partnerships with Māori health providers to support intern training and education.

#### 2.4 – Notes – Relationships to support medical education

- (i) *District training providers are encouraged to share resources, guidance documents and knowledge about prevocational medical training, including those relating to accreditation processes, across local and regional boundaries. Regional training hubs and training networks may play a key role in the intern training programme.*
- (ii) *Effective working relationships should be formed with other organisations and networks including Council, medical schools, medical colleges, primary health organisations, other health service localities, Māori health sector representatives and community-based healthcare providers.*

## 3. The intern training programme

### Standard 3.1: Programme components

#### 3.1.1

The intern training programme is structured to support interns to attain the learning outcomes outlined in the 14 learning activities of the curriculum.

#### 3.1.2

The intern training programme requires the satisfactory completion of eight accredited clinical attachments, which in aggregate provide a broad-based experience of medical practice.

#### 3.1.3

The **district training provider** selects suitable clinical attachments for training based on the experiences that interns can expect to achieve, including the:

- workload for the intern and the clinical unit
- complexity of the given clinical setting
- mix of training experiences across the selected clinical attachments and how they are combined to support achievement of the goals of the intern training programme.

#### 3.1.4

The **district training provider** has processes that ensure that interns receive the supervision and opportunities to:

- enhance their skills, understanding and knowledge of hauora Māori

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- develop their cultural safety and cultural competence, and
  - deliver patient care in a culturally-safe manner.
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### 3.1.5

Processes are in place to ensure that, over the course of the two prevocational training years each intern completes at least one community-based attachment.

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### 3.1.6

Interns are not rostered on nights during the first six weeks of PGY1.

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### 3.1.7

There is a formalised process to ensure that interns working on nights are appropriately supported. This includes protocols that clearly detail how the intern may access advice or assistance overnight from senior medical staff.

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### 3.1.8

There are procedures in place for structured handovers between clinical teams and between shifts (morning, evening, nights and weekends) to promote continuity of quality care. The **district training provider** ensures that interns understand their role and responsibilities in handover.

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### 3.1.9

The **district training provider** ensures adherence to the Council's statement on obtaining informed consent.

#### 3.1 – Notes – Programme components

- (i) Interns are expected to regularly review and record self-reflections and proficiency against all 14 learning activities, indicating areas of strength and areas for further development, which should then inform goals in their professional development plan (PDP).
- (ii) Clinical attachments are 13 weeks. Satisfactory completion of at least 10 weeks (full time equivalent) in each clinical attachment is a requirement for registration in a general scope of practice. Full time is equivalent to a minimum of 40 hours per week. 10 weeks participation in an attachment is considered as a guideline to the standard time requirement but the individual circumstances for each intern must be considered (please refer to the Policy on prevocational medical training for further information).
- (iii) Interns may join a vocational training programme in PGY2, however any requirements for that programme will be in addition to the requirements of the intern training programme. Interns participating in a vocational training must continue to work under supervision in prevocational medical training accredited clinical attachments, maintain their PDP and continue to record reflections against the 14 learning activities in ePort.
- (iv) Please refer to Council's:
  - [Statement on Cultural Safety](#)
  - [He Ara Hauora Māori: a Pathway to Māori Health Equity](#)
  - [Cultural Safety Baseline Data Report](#)
- (v) An intern must complete PGY2 prior to being appointed to a more senior position.
- (vi) Every intern is required to complete one clinical attachment in a community-based setting over the course of the intern training programme. Requirements for community-based attachments can be found in the [Accreditation standards for clinical attachments](#) and the [Definition of a community-based attachment](#).
- (vii) Interns may be rostered on nights within the first six months of registration if a doctor registered in that vocational scope is available for assistance.
- (viii) The district training provider ensures that [Council's statement on informed consent](#) and the training organisation's policy is understood by interns and all relevant staff.

## Standard 3.2: ePort

### 3.2.1

There is a system to ensure that each intern maintains their ePort as an adequate record of their learning and training experiences from their clinical attachments and other learning activities.

### 3.2.2

There is a system to ensure that each intern maintains a PDP in ePort that identifies their goals and learning objectives which are informed by the learning activities, mid and end of clinical attachment assessments, personal interests and vocational aspirations.

### 3.2.3

There are mechanisms to ensure that the clinical supervisor and the prevocational educational supervisor regularly review the goals in the intern's PDP with the intern.

### 3.2.4

Training is facilitated for PGY1s on goal setting in the PDP within the first month of the intern training programme.

#### 3.2 – Notes – ePort

- (i) *The PDP should include goals informed by:*
  - *the intern's level of proficiency against the 14 learning activities*
  - *the learning opportunities available on the particular clinical attachment*
  - *mid-attachment feedback*
  - *areas to focus on for further development that have been identified in the end of clinical attachment assessment*
  - *additional personal objectives related to vocational aspirations and other professional interests.*
- (ii) *The prevocational educational supervisor should encourage interns to set goals across more than one learning activity. Each intern should set at least three goals for each clinical attachment, with a maximum of eight. The goals should be focused on the current clinical attachment however some may be longer term.*
- (iii) *District training providers ensure that clinical supervisors understand their role in encouraging interns to set goals at the beginning of each clinical attachment that are appropriate for the attachment and the intern's needs.*
- (iv) *Training for interns about goal-setting should be provided during the orientation programme or within the first month as a teaching session within the formal education programme.*
- (v) *The various ways in which interns can attain proficiency in each learning activity should be emphasised to interns and those involved in prevocational medical training.*

## Standard 3.3: Formal education programme

### 3.3.1

The intern training programme includes a formal education programme that supports interns to achieve the learning outcomes outlined in the 14 learning activities that are not generally available through the completion of clinical attachments.

### 3.3.2

The intern training programme ensures that interns can attend at least two thirds of formal education sessions, by structuring the formal education sessions so that barriers to attendance are minimised.

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### 3.3.3

The **district training provider** ensures that all PGY2s attend structured education sessions.

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### 3.3.4

The formal education programme provides content on hauora Māori and tikanga Māori, and Māori health equity, including the relationship between culture and health.

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### 3.3.5

The formal education programme provides opportunity for interns to develop skills in self-care and peer support, including time management, and identifying and managing stress and burn-out.

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### 3.3.6

Interns are provided with opportunities for additional work-based teaching and training.

#### 3.3 – Notes – Formal education programme

- (i) *A record should be kept of attendance at the training sessions to ensure all interns are attending the majority of sessions. The district training provider should look at trends of attendance to ensure there are no reoccurring barriers which are preventing interns attending.*
- (ii) *Council defines two thirds attendance as being 67% of attendance across the entire teaching programme for the year.*
- (iii) *The formal education programme should include:*
  - *Teaching sessions with consultants and other health professionals.*
  - *Opportunities to develop and practice clinical skills within a simulated environment.*
  - *Council's statements and publications, for example Good Medical Practice.*
- (iv) *Structured teaching and learning sessions for PGY2s should be monitored. These sessions may be delivered by a formal education programme designed specifically for PGY2s, or structured speciality-specific teaching on clinical attachments.*
- (v) *The district training provider ensures support for intern attendance from management and senior medical and nursing staff.*
- (vi) *Interns are expected to be aware of their own cultural values and beliefs, and to interact with each individual in a manner appropriate to that person's culture.*

## Standard 3.4: Orientation

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### 3.4.1

An orientation programme is provided for interns beginning employment at the start of the intern year and for interns beginning employment part way through the year, to ensure familiarity with policies and processes relevant to their practice and the intern training programme.

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### 3.4.2

Orientation, including written descriptions, is provided at the start of each clinical attachment, ensuring familiarity with key staff, systems, policies, and processes relevant to that clinical attachment.

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## Standard 3.5: Flexible training

### 3.5.1

There are procedures in place to consider applications for flexible training arrangements which align with the training organisation's policy on flexible training.

#### 3.5 – Notes – Flexible training

- (i) *Interns with flexible working arrangements (undertaking part-time work) need to work at least 0.5 FTE for it to count towards meeting the prevocational requirements. However, they will need to complete a further attachment of 0.5 FTE for it to count towards the prevocational requirements. Full time is equivalent to a minimum of 40 hours per week.*

## 4. Assessment and supervision

### Standard 4.1: Processes and systems

#### 4.1.1

There are systems in place to ensure that all interns and those involved in prevocational training understand the requirements of the intern training programme.

#### 4.1.2

All staff involved in intern training have access to professional development activities to support their teaching and educational practice.

#### 4.1.3

The **district training provider** ensures that adequate time for supervision and training is available to prevocational educational supervisors and clinical supervisors to meet the requirements of their roles.

#### 4.1 – Notes – Process and systems

- (i) *District training providers can access information on Council's website to support those involved in prevocational training. This includes information on the training programme and guides ([Prevocational PGY1/PGY2 training requirements](#)) and training slides on ePort.*
- (ii) *District training providers need to ensure that clinical supervisors have access to relevant training in supervision and assessment at a local and regional level. District training providers need to enable this by coordinating training using external trainers or by ensuring supervisors attend training provided by medical colleges for their vocational training programmes, or training provided by medical schools for supervision of medical students in clinical settings.*
- (iii) *Council's Memorandum of Understanding with all district training providers outlines the requirements for intern learning. This includes the requirement that each prevocational educational supervisor is allocated 0.10 FTE protected time for up to 10 interns to carry out the functions of the role.*

### Standard 4.2: Supervision – Prevocational educational supervisors

#### 4.2.1

There is an appropriate ratio of prevocational educational supervisors in place to oversee the training and education of interns in both PGY1 and PGY2.

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#### 4.2.2

Prevocational educational supervisors attend an annual prevocational educational supervisor meeting held by the Council.

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#### 4.2.3

There is oversight of the prevocational educational supervisors by the CMO (or delegate) to ensure that they are effectively fulfilling the obligations of their role.

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#### 4.2.4

Administrative support is available to prevocational educational supervisors so they can carry out their roles effectively.

#### 4.2 – Notes – Supervision – Prevocational educational supervisors

- (i) *The prevocational educational supervisor to intern ratio is one prevocational educational supervisor for up to ten interns,*
- (ii) *If an intern has more than one prevocational educational supervisor over the course of the year:*
  - *A verbal handover should occur between the prevocational educational supervisors to discuss the intern's progress and any concerns.*
  - *A meeting should be held between the intern and new prevocational educational supervisor as soon as the change occurs to form the supervisory relationship.*

### Standard 4.3: Supervision – Clinical supervisors

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#### 4.3.1

Mechanisms are in place to ensure the clinical supervisors have the appropriate competencies, skills, knowledge and authority to meet the requirements of their role.

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#### 4.3.2

Interns are clinically supervised at a level appropriate to their experience and responsibilities.

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#### 4.3.3

Clinical supervisors undertake relevant training in supervision and assessment as soon as practicable after beginning their supervisory role. This must be within 12 months of appointment as a clinical supervisor.

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#### 4.3.4

The **district training provider** maintains a small group of clinical supervisors for relief clinical attachments.

#### 4.3 – Notes – Supervision – Clinical supervisors

- (i) *Supervision is a condition of registration for all new doctors in Aotearoa New Zealand. It enables the doctors' performance to be assessed to ensure the health and safety of the public while the doctors become familiar with the Aotearoa New Zealand's health system and required standard of practice. All those who teach, supervise, counsel, employ or work with interns are responsible for patient safety. Accountable supervision contributes to patient safety.*
- (ii) *Clinical supervisors should assist an intern's professional development and support interns in achieving their learning objectives. Supervision includes direct and indirect monitoring of an intern's progress and performance and providing constructive feedback.*

- (iii) *Clinical supervisors must be vocationally registered in a relevant vocational scope to the clinical attachment and the work of the intern. Supervision on a day-to-day basis may be delegated to a representative, for example a registrar.*
- (iv) *It is recognised that the level of day-to-day supervision required for PGY2 will decrease, as the intern moves to more independent practice. Accredited clinical attachments will ensure an ongoing quality learning environment and an appropriate level of support.*
- (v) *District training providers need to ensure that clinical supervisors have access to relevant training in supervision and assessment at a local and regional level. District training providers need to enable this by coordinating training using external trainers or by ensuring supervisors attend training provided by medical colleges for their vocational training programmes, or training provided by medical schools for supervision of medical students in clinical settings.*
- (vi) *To supplement training coordinated by the district training provider, an introductory level 1 online course including interactive videos is available on ePort. All new clinical supervisors should complete this programme. Others should be encouraged to complete it as a refresher course.*

## Standard 4.4: Feedback and assessment

### 4.4.1

Systems are in place to ensure that regular, formal feedback is provided to interns and documented in ePort on their performance within each clinical attachment, including end of clinical attachment assessments. This should also cover the intern's progress in completing the goals in their PDP and the intern's self-reflections against the 14 learning activities.

### 4.4.2

There are processes to identify interns who are not performing at the required standard of competence. These ensure that the clinical supervisor discusses concerns with the intern, the prevocational educational supervisor, and that the CMO (or delegate) is advised when appropriate. A remediation plan must be developed, documented, and implemented with a focus on supporting the intern and patient safety.

### 4.4.3

There are processes in place to ensure prevocational educational supervisors inform the Council in a timely manner of interns not performing at the required standard of competence.

#### 4.4 – Notes – Feedback and assessment

- (i) *Formal feedback will include review of the intern's ePort by the clinical supervisor at the beginning, middle and end of each clinical attachment and by the prevocational educational supervisor at the beginning of PGY1 and PGY2 and at the end of each clinical attachment. These discussions will be summarised in ePort. Revision of the intern's PDP goals will be based on these comments, areas to focus on for further development identified in the end of clinical attachment assessments, and evolving personal objectives related to vocational aspirations and professional interests.*
- (ii) *Clinical supervisors should be familiar with their district training provider's processes for supporting interns. They must engage with the prevocational educational supervisor when there are any concerns about an intern's performance.*
- (iii) *Prevocational educational supervisors should be the first point of contact when there are concerns about performance or patient safety issues. It is recommended that prevocational educational supervisors liaise closely with the resident medical officer (RMO) unit or its equivalent, the CMO (or delegate), human resource management and other prevocational educational supervisors (both locally and nationally) for the management of intern performance. Please refer to the [Prevocational Educational Supervisors Guide](#) for further information.*

- (iv) *Training providers must have processes in place to act if an intern's performance poses a risk or potential risk to patient safety. This process must include notifying the prevocational educational supervisor and the CMO (or their delegate) and Council when appropriate.*

## Standard 4.5: Advisory panel to recommend registration in the General scope of practice

### 4.5.1

There are established advisory panels to consider progress of each intern at the end of the PGY1 year that comprise:

- a CMO or delegate (who will chair the panel)
- the intern's prevocational educational supervisor
- a second prevocational educational supervisor
- a layperson.

### 4.5.2

The panel follows the Council's Advisory Panel Guide & ePort guide for Advisory Panel members.

### 4.5.3

There is a process in place to ensure that each eligible PGY1 is considered by an advisory panel.

### 4.5.4

There is a process in place to ensure that all interns who are eligible to apply for registration in the General scope of practice have applied in ePort.

### 4.5.5

The advisory panel bases its recommendation for registration in the General scope of practice on whether the intern has met the Council's requirements for registration in the General scope of practice.

### 4.5 – Notes – Advisory panel to recommend registration in the General scope of practice

- (i) *The layperson must not be, and should not have previously been, a registered health practitioner and must not be an employee of the district training provider.*
- (ii) *District training providers will need to have processes in place to ensure meetings of the advisory panel are organised in a way which ensures interns can move from provisional general registration to general registration in a timely manner. Any process will allow for annual leave of panel members.*
- (iii) *The district training provider must keep accurate records of the administration of the advisory panel.*
- (iv) *The Council's policy on the ACLS requirement is available at [Advanced cardiac life support requirements for PGY1 interns](#).*
- (v) *The PGY1 requirements are available on Council's [website](#).*

## Standard 4.6: End of PGY2 – removal of endorsement

### 4.6.1

There is a process in place to ensure that all eligible PGY2s have applied to have the endorsement removed from their practising certificates.

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#### 4.6.2

There is a process in place to ensure that prevocational educational supervisors have reviewed the progress of interns who have applied to have their endorsement removed.

#### 4.6 – Notes – End of PGY2 – removal of endorsement on practising certificate

(i) An endorsement is placed on the practising certificates of PGY2 interns, reflecting the imposition of programme requirements under section 40 of the HPCAA. These requirements are that:

- Interns must complete four Council-accredited clinical attachments. All accredited clinical attachments will span 13-weeks.
- Interns must continue to set goals in the PDP and work towards achieving these goals. During PGY2, interns must continue to record self-reflections and show progress in attaining proficiency in each of the 14 learning activities.

## 5. Monitoring and evaluation of the intern training programme

### Standard 5.1: Monitoring and evaluation

#### 5.1.1

Processes and systems are in place to monitor the intern training programme with input from interns and supervisors.

#### 5.1.2

There are mechanisms in place that enable interns to provide anonymous feedback about their educational experience on each clinical attachment.

#### 5.1.3

There are mechanisms that allow feedback from interns and supervisors to be incorporated into quality improvement strategies for the intern training programme.

#### 5.1.4

There are mechanisms in place that enable interns to provide anonymous feedback on their prevocational educational supervisors, RMO unit staff and others involved in intern training.

#### 5.1.5

The **district training provider** routinely evaluates supervisor effectiveness taking into account feedback from interns.

#### 5 – Notes – Monitoring and evaluation of the intern training programme

(i) Council encourages the use of Torohia in district training providers monitoring processes. Other options that are available to district training providers for collecting feedback from interns about a clinical attachment include the Postgraduate Hospital Educational Environment Measure (PHEEM) tool. However, district training providers can use their own tool for collecting feedback.

## 6. Implementing the education and training framework

### Standard 6.1: Establishing and allocating accredited clinical attachments

#### 6.1.1

Processes and mechanisms are in place to ensure the currency of accredited clinical attachments.

#### 6.1.2

The **district training provider** has processes for establishing new clinical attachments.

#### 6.1.3

The process of allocation of interns to clinical attachments is transparent and fair.

#### 6.1.4

There is a system to ensure that interns' preferences for clinical attachments are considered, taking into account the 14 learning activities and the intern's individual PDP goals in the context of available positions.

#### 6.1 – Notes – Establishing and allocating accredited clinical attachments

- (i) *Ensuring the currency of clinical attachments includes updating ePort descriptions and recording the correct clinical supervisors for the attachment.*
- (ii) *Please refer to Council's [accreditation standards for clinical attachments](#).*

### Standard 6.2: Welfare and support

#### 6.2.1

The duties, rostering, working hours and supervision of interns are consistent with the delivery of high-quality training and safe patient care.

#### 6.2.2

The **district training provider** ensures a safe working and training environment, which is free from bullying, discrimination, and sexual harassment.

#### 6.2.3

The **district training provider** ensures a culturally safe environment.

#### 6.2.4

Interns have access to personal counselling, and career advice. These services are publicised to interns and their supervisors.

#### 6.2.5

The procedure for accessing appropriate professional development leave is published, fair and practical.

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### 6.2.6

Interns are actively encouraged to maintain their own health and welfare and to register with a general practitioner.

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### 6.2.7

Applications for annual leave are dealt with fairly and transparently.

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### 6.2.8

The **district training provider** has procedures in place to consider leave applications specific to additional cultural obligations for Māori interns and implements these procedures in accordance with the training organisation's policy.

#### 6.2 – Notes – Welfare and support

- (i) *Ensuring a safe working and training environment, and ensuring a culturally safe environment, requires proactive and purposeful attention and a systematic focus, with a strong leadership commitment and a culture of shared responsibility.*  
*A safe working and training environment requires having clear policies, communicating acceptable and unacceptable behaviours, having appropriate training for staff on these, having confidential and accessible pathways to hear of any concerns, and responding promptly and fairly to any concerns.*  
*A culturally safe environment is one where people reflect on how their own views and biases impact on their clinical decision making and interactions with others – whether patients, their whānau/family, or colleagues – and engenders a commitment from all to acknowledge and address these. It allows space for culturally respectful communication and behaviour, and recognises the diversity of cultures within the environment. Council's [statement on cultural safety](#) is available on our website.*
- (ii) *Training providers may encourage interns to maintain their own health and welfare by:*
- *providing a list to the interns of general practitioners willing to take on new patients*
  - *advising interns that self-prescribing and prescribing for friends and family is a breach of Council's statement [Treating yourself and those close to you](#).*
- (iii) *Māori interns may have:*
- *expectations placed on them by their local Māori communities, about care that the intern may provide for them.*
  - *a wide set of whānau and cultural obligations, including, for example, marae-based responsibilities and attending tangihanga of extended whānau members and*  
*Responding to these obligations are an important dimension of Māori interns' wellbeing. The engagement of Māori interns in their culture and with their local Māori community will also bring value to training providers, through enhancing its wider cultural understanding, ability to ensure the provision of culturally safe care and develop cultural competence among its workforce and strengthening local relationships.*
- (iv) *While training providers will need to ensure training and service requirements are fulfilled, enabling Māori interns to respond to their cultural obligations is likely to require a flexible approach. This may extend to flexible training arrangements and HR processes. However, the district training provider must ensure that the accreditation standards for prevocational medical training are met.*

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## Standard 6.3: Communication with interns

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### 6.3.1

Clear and easily accessible information about the intern training programme is provided to interns.

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## Standard 6.4: Resolution of training problems and disputes

### 6.4.1

There are processes to support interns to address problems with training supervision and training requirements that maintain appropriate confidentiality.

### 6.4.2

There are formal processes for timely resolution of training-related disputes. These are documented with reference to the training organisation's policy on review and resolution of training-related disputes.

## 7. Education resources and facilities

### Standard 7.1: Education resources and facilities

#### 7.1.1

Interns have access to appropriate and up-to-date educational resources.

#### 7.1.2

Intern facilities and infrastructure related to prevocational training are available, maintained, and of an appropriate standard for use, including when on-call.

#### 7 – Notes – Facilities

##### (i) Educational resources may include

- e-learning modules
- Council's statements
- [Cole's Medical practice in New Zealand](#)
- Council's [Good medical practice](#)
- continuing medical education sessions
- skills lab or an appropriate venue for simulation training.

##### (ii) Facilities and infrastructure includes:

- computer facilities including videoconferencing capabilities
- access to internet and intranet services (e.g. Wi-Fi)
- library services
- appropriate meeting or training venue/s for continuing medical education sessions
- common room for interns.