

PREVOCATIONAL MEDICAL TRAINING FOR DOCTORS IN NEW ZEALAND



Accreditation standards for clinical attachments

Including accreditation standards for community based clinical attachments

Introduction

Prevocational medical training (the intern training programme) spans the two years following registration with Council and includes both postgraduate year 1 (PGY1) and postgraduate year 2 (PGY2). Prevocational medical training must be completed by all graduates of New Zealand and Australian accredited medical schools and doctors who have sat and passed the New Zealand Registration Examination (NZREX Clinical). Doctors undertaking this training are referred to as interns.

These accreditation standards are to be considered in conjunction with the *Accreditation standards for training providers*. The training provider must be accredited for the purposes of providing prevocational medical training. The training provider must ensure that there are a variety of accredited clinical attachments that provide quality supervision and assessment for interns to gain a breadth of experience with opportunity to achieve the learning outcomes in the *New Zealand Curriculum Framework for prevocational medical training* (NZCF). Clinical attachments may only be accredited if they form part of the intern training programme provided by an accredited training provider. Clinical attachments take place in a variety of health care settings, including hospitals and community based settings.

By 2020 every intern will be required to complete one clinical attachment in a community based setting over the course of the intern training programme. Council approved a staged transition working towards 100% compliance by November 2020. Training providers will need to demonstrate progress towards this goal during the transition period.

Standards relating to Māori health, health inequities and cultural competence throughout the *Accreditation standards for clinical attachments* are interim standards, and will be further updated in 2019.

Applying for accreditation of clinical attachments

Applications for accreditation of clinical attachments must be made by the training provider (DHB). To apply for accreditation of a clinical attachment, an electronic application must be completed through ePort. The nominated clinical supervisors of the clinical attachment are required to complete the supervisor form as part of the application process, which is then submitted to Council. Prevocational educational supervisors, clinical directors of training, resident medical officer (RMO) and medical unit staff and chief medical officers (CMOs) have the functionality to create and complete the clinical attachment accreditation application. A prevocational educational supervisor must review the content of the application before submitting it to Council.

The application for accreditation of clinical attachments does not ask for evidence on how the training provider meets the standards. However, as part of the training provider accreditation, a random selection of accredited clinical attachments will be reviewed to verify the information provided in the attachment accreditation applications.

Interns must not commence any clinical attachment until it has been accredited by Council.

1 STRUCTURE OF CLINICAL ATTACHMENT

- 1.1 The duration of each clinical attachment is 13 weeks.
- 1.2 There is at least one nominated clinical supervisor, who is registered within the relevant vocational scope of practice, who has overall responsibility for the intern's training on each clinical attachment.
- 1.3 All clinical attachments have clear lines of accountability and reporting at all times and mechanisms are in place to ensure that the intern is well supported in delivering care and achieving their training goals, including when the specified clinical supervisor is not readily available.
- 1.4 The intern is an integral part of a team, or during relieving attachments there is comparable supervision for their clinical work and appropriate support for an intern to achieve their training goals.
- 1.5 Each clinical attachment lists the specific NZCF learning outcomes that can generally be achieved during the attachment.
- 1.6 Interns attend the training provider's formal education programme and participate in other approved learning opportunities. Time for intern teaching and learning must be allocated within the clinical attachment.
- 1.7 Interns on each clinical attachment are provided with orientation that includes familiarisation with key staff, systems, policies and processes relevant to that attachment.

1 – Notes – Structure of clinical attachment

- (i) Each clinical attachment should have more than one (with a maximum of four) clinical supervisors. This is to provide ongoing support and cover for leave of other clinical supervisors on the attachment.
- (ii) The generic learning outcomes in the NZCF under the professionalism and communication sections are expected to be woven through all clinical attachments. Focus should be placed on identifying learning outcomes from the clinical management, clinical problems and conditions, and procedures and interventions sections that are relevant to the practice of the team. However some learning outcomes from the professionalism and communication sections may be identified.
- (iii) Additional information, including objectives for the clinical attachment, should be uploaded as part of the clinical attachment application for accreditation (Section B, 2. Optional – other learning objectives). This information is then available to the clinical supervisors, prevocational educational supervisors and interns.

2 SUPERVISION

- 2.1 The clinical supervisors understand their role and responsibilities and demonstrates a commitment to intern training and assisting interns to meet learning objectives.
- 2.2 Clinical supervisors undertake relevant training in supervision and assessment as soon as practicable after commencing their supervisory role. This must be within 12 months of appointment as a clinical supervisor.
- 2.3 The supervision arrangements are clear and explicit.
- 2.4 Interns are supervised at a level appropriate to their experience and responsibilities at all times.
- 2.5 The clinical supervisor meets formally with each intern:
 - At the start of each clinical attachment to discuss the learning opportunities for that clinical attachment and to assist the intern develop goals in their PDP.
 - At the mid-point of the clinical attachment to provide feedback on the intern's progress and performance, review and provide feedback on the goals in the PDP, identifying the areas the intern should focus on in order to satisfactorily complete the clinical attachment.
 - At the end of the clinical attachment to discuss the intern's overall performance, review the PDP and provide feedback on strengths as well as areas to focus on for the intern's professional improvement.

- 2.6 Feedback is captured in ePort at the beginning and mid-point of the clinical attachment, and in the end of clinical attachment assessment.
- 2.7 There are mechanisms in place to ensure clinical supervisors of relief clinical attachments seek feedback from those who have worked with the intern over the course of the attachment in order to provide feedback and complete the clinical attachment meetings and end of clinical attachment assessment in ePort.
- 2.8 There are procedures in place to immediately address any concerns about patient safety involving an intern.
- 2.9 There are mechanisms to ensure the clinical supervisor identifies interns who are not performing at the required standard of competence at an early stage, and communicates with the prevocational educational supervisor with the aim of providing appropriate remediation for the intern.

2 – Notes – Supervision

- (i) Supervision on a day-to-day basis may be delegated by the clinical supervisor to a registrar or alternative appropriate representative, although the clinical supervisor remains responsible for the quality of that supervision.
- (ii) At the beginning of each clinical attachment interns should receive an outline of the assessment process including who is responsible for giving feedback, and how this information will be recorded. There should be opportunities for input from a variety of sources including other team members. In particular clinical supervisors should seek feedback from any registrars on that clinical attachment.
- (iii) The clinical supervisor will complete the end of clinical attachment assessment in ePort for each intern that they supervise.
- (iv) Clinical supervisors of relief clinical attachments should seek feedback from the wider team, including consultants, registrars and nurses. The clinical supervisor of relief attachments will require additional support to ensure that they understand the different nature of their role and how to be effective when providing support to interns they are not directly working with.
- (v) Clinical supervisors must engage with the prevocational educational supervisor when there are any concerns about an intern's performance.
- (vi) Copies of end of clinical attachment assessments that have been rated as unsatisfactory must be forwarded to Council's office by the prevocational educational supervisor.
- (vii) Training providers must have processes in place to take action if an intern's performance poses any 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.

3 OTHER LEARNING ACTIVITIES

- 3.1 Information is provided by the clinical supervisor on the work-based teaching and educational opportunities available to the intern during the clinical attachment.
- 3.2 There are systems in place to facilitate an intern's attendance at the intern formal education programme and other learning activities.

4 COMMUNITY-BASED CLINICAL ATTACHMENTS

- 4.1 The clinical attachment is community-focused and provides for direct contact with patients or public health services.
- 4.2 The community-based clinical attachment provides opportunity for the community management of medical illness and/or mental health, which may include early detection of disease, population health, and acute and chronic care management.
- 4.3 The community-based clinical attachment familiarises interns with the delivery of health care outside the hospital setting, including an understanding of the interface between primary and secondary care and the wider health care network.

4 – Notes – Community-based clinical attachments

- (i) Community-based clinical attachments can take place in a wide variety of settings, including but not limited to general practice and urgent care. This may include rural and regional locations, and settings that provide experience in the provision of health care to Māori.
- (ii) A community based clinical attachment should include provision for the intern to access the weekly formal education sessions delivered by the training provider. If this is not practicable, alternative arrangements for formal education need to be put in place.
- (iii) The community-based clinical attachments will not usually include a hospital-based attachment, with the exception of rural hospitals that have been accredited for rural hospital vocational training and that are run predominately by doctors registered in the vocational scopes of general practice or rural hospital medicine.