المعهد الوطني للتخصصات الصحية
National Institue for Health Specialities

Guideline for Providing Evidence in NIHS Institutional Accreditation Service

Version 1

National Institution for Health Specialties

United Arab Emirates

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About the National Institute for Health Specialties

The National Institute for Health Specialties (NIHS) was established by Cabinet Decree No. 28 of 2014. It serves as a national institution responsible for leading, regulating, and organizing professional development for the health workforce, with a particular focus on specialty training.

Mandate and Key Functions

The NIHS is authorized to accredit hospitals and health institutions to host specialty programs that lead to postgraduate qualifications. Its primary functions include:

- **Setting Standards**: Establish standards for specialty health programs and accreditation criteria for institutions and programs.
- **Institutional Evaluation**: Evaluate and approve healthcare institutions for delivering specialty training.
- **Accreditation**: Accredit hospitals, medical centers, and specialty programs.
- **Curriculum Approval**: Approve specialty training curriculums in the UAE.
- **Program Approval**: Approve Residency and Fellowship programs.
- **Examinations**: Conduct specialized professional examinations adhering to international standards.
- **Certification**: Issue certificates for higher health specialties (board and fellowship).
- **Continuing Education**: Approve standards for continuing medical education and continuing professional development programs in health specialties.
- **Admission Standards**: Develop admission standards and conduct admission exams for specialty training programs.
- **National Registry**: Establish a national registry for all health specialties and qualifications within the country.

The NIHS is dedicated to developing a highly qualified health workforce capable of supporting the health system and promoting health and wellbeing.

For more information about the *Guidelines for Evidence in the NIHS Institutional Accreditation Service, please* contact:

National Institution for Health Specialties
Phone: +971(3) 7137576
Email: nihs@uaeu.ac.ae
Web: www.NIHS.uaeu.ac.ae

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ABBREVIATIONS

TERM	DEFINITION
NIHS	National Institute for Health Specialties
DIO	Designated Institutional Official
PD	Program Director
APD	Associate Program Director
CCC	Clinical Competency Committee
PEC	Program Evaluation Committee
GMEC	Graduate Medical Education Committee
FTE	Full Time Equivalent
PLA	Program Letter of Agreement

Introduction

The National Institute for Health Specialties (NIHS) produces this document as part of its role in accrediting institutions to deliver residency and fellowship training programs. Mandated by Cabinet Decree No. 28 of 2014, NIHS is responsible for accrediting hospitals and health institutions to host specialty programs leading to postgraduate qualifications. This document is designed to assist sponsoring institutions in preparing their institutional accreditation applications and gathering the necessary information and documentation for accreditation.

Purpose

This document serves as a guide for sponsoring institutions seeking accreditation from NIHS. It outlines the required evidence to be included with the accreditation application to ensure compliance with NIHS accreditation standards.

How to Use This Document

This document serves two primary purposes:

- **For Sponsoring Institutions (SI)**: It assists institutions in seeking accreditation to deliver residency and fellowship programs. Institutions can reference this document to understand the evidence required for submitting their accreditation applications to NIHS.
- **For NIHS Accreditation Apparatus and Surveyors**: It acts as a benchmark for evaluating institutional accreditation applications, guiding surveyors during site visits, and informing accreditation decisions.

Structure of Institutional Accreditation Requirements

The NIHS Institutional Accreditation requirements are organized into domains, components, and requirements. These five domains — governance, training environment, residents/fellows, faculty, and continuous renewal and innovation — encompass the core aspects of residency and fellowship training. Within these domains, there are 17 components, further divided into 70 specific requirements that institutions must fulfill for accreditation.

Below is the list of requirements along with the evidence guidelines:

Domain 1: Governance

Component 1.1. Governance Structures

Accreditation Requirements	Evidence guidelines
1.1.1 The availability of a written statement of commitment of the SI to provide the necessary educational, financial, and human resources to support GME. The statement must be signed by representatives of the SI's governing body, administration, and GME leadership within a minimum of one year prior to an institutional site visit.	▪ Provide an official commitment letter affirming its dedication to supplying the required educational, financial, and human resources for Graduate Medical Education (GME). This letter should be signed by representatives from the SI's governing body and administration (senior officials authorized persons such as CEO, CMO, CFO and HR Director).
1.1.2 The availability of an organized administrative system, led by a designated institutional official (DIO) in collaboration with a Graduate Medical Education Committee (GMEC), must oversee all programs in the SI.	▪ Provide a copy of the organizational chart of the SI, incorporating GME. ▪ Include a copy of the organizational chart of the education/academic affairs department, illustrating the administrative system responsible for overseeing GME programs within the Sponsoring Institution. These charts should visually represent reporting relationships and indicate the placement of graduate medical education and the DIO within the institutional structure. ▪ The GME organizational chart should feature the DIO, GMEC, Program Directors (PDs), and the Clinical Competency Committee (CCC) and Program Evaluation Committee (PEC).
1.1.3 DIO appointed according to the requirements.	▪ Provide the DIO appointment letter signed by authorized officials, indicating their allocated protected time in full-time equivalents (FTE). *Note:* The definition of DIO protected time is clearly outlined in the NIHS institutional accreditation requirements manual.

1.1.4 GMEC constituted according to the requirements	▪ The terms of reference of the GMEC, that oversees training experiences at the sponsoring institution.
1.1.5 GMEC voting membership include the DIO, residents/fellows nominated by their peers, representative PDs, and administrators.	▪ Provide the GMEC membership resolution, listing the names of GMEC members. If applicable, specify their specialty program affiliation (e.g., internal medicine, general surgery, anesthesiology) and their anticipated role in the program (e.g., PD, program coordinator). Also, include the position titles of other institutional administrators. Be sure to include the residency/fellowship program and post-graduate year for all resident/fellow members.
1.1.6 The GMEC meet at least quarterly and maintain written minutes.	▪ Submit the minutes from all GMEC meetings held within one year of the application, arranged chronologically. Exclude any agenda attachments or subcommittee minutes.
1.1.7 Procedures to ensure that DIO designee can perform the duties of the DIO in his/her absence.	▪ DIO designee appointment letter signed by Authorized Person.
1.1.8 The availability of GMEC annual report to the SI leadership and governing body of major participating sites. The content of the annual report is as per the requirements.	▪ The Annual Graduate Medical Education Report for the previous academic year should include information on the activities of the GMEC, focusing on resident/fellow supervision, responsibilities, evaluations, compliance with duty hour standards, and involvement in patient safety and quality of care education. Additionally, provide details on faculty development training, a list of residents/fellows, core faculty, and graduates, as well as key performance indicators.

Component 1.2. Governance Relationships

Accreditation Requirements	Evidence guidelines
1.2.1. Communication mechanisms exist between the GMEC and all PDs within the institution.	▪ Documentation of regular meetings or correspondence between the GMEC and PDs. ▪ Meeting agendas and minutes showing discussions related to GMEC - PD communication. ▪ Email correspondence or communication logs indicating exchanges between the GMEC and PDs. ▪ Policies or procedures outlining the communication protocols between the GMEC and PDs. ▪ Surveys or feedback forms from PDs assessing the effectiveness of communication with the GMEC. ▪ Records of any collaborative projects or initiatives between the GMEC and PDs. ▪ Evidence of dissemination of GMEC decisions, policies, or updates to PDs. ▪ Training or orientation materials provided to PDs regarding their role in communication with the GMEC.
1.2.2. he presence of effective communication mechanisms between PDs and the site directors at each participating site to maintain proper oversight at all clinical sites.	▪ Documentation of regular meetings or correspondence between PDs and site directors. ▪ Meeting agendas and minutes showing discussions related to program oversight and communication between PDs and site directors. ▪ Email correspondence or communication logs indicating exchanges between PDs and site directors. ▪ Policies or procedures outlining the communication protocols between PDs and site directors.

	▪ Reports or evaluations assessing the effectiveness of communication and oversight between PDs and site directors. ▪ Records of any collaborative projects or initiatives between PDs and site directors aimed at improving oversight. ▪ Evidence of dissemination of program policies, updates, or directives to site directors and vice versa. ▪ Training or orientation materials provided to site directors regarding their role in communication and oversight within the program.
1.2.3. Integration of training with clinical governance e.g. committees' membership.	▪ Documentation of committee membership lists, indicating the representation of training program faculty or leadership. ▪ Meeting agendas and minutes demonstrating discussions and decisions related to the integration of training with clinical governance. ▪ Policies or procedures outlining the involvement of training program representatives in clinical governance committees. ▪ Reports or evaluations assessing the effectiveness of collaboration between training programs and clinical governance committees. ▪ Evidence of joint initiatives or projects between training programs and clinical governance committees. ▪ Records of training program faculty or leadership participation in clinical governance activities, such as quality improvement projects or patient safety initiatives. ▪ Feedback from training program faculty or leadership regarding their

	involvement in clinical governance committees and the impact on training integration. ▪ Training program curricula or documentation demonstrating alignment with clinical governance objectives and priorities.
1.2.4. All programs have established program letters of agreement (PLA) with their participating sites.	▪ Provide copies of valid PLA exists with each participating sites. PLAs should be: ▪ Valid for 5 years period. ▪ Approved by the DIO. ▪ Specify the duration and content of the educational experience. ▪ State the policies and procedures that will govern resident/fellow education during the assignment. ▪ Identify the faculty members who will assume educational and supervisory responsibility for residents/fellows. ▪ Specify the responsibilities for teaching, supervision, and formal evaluation of residents/fellows. ▪ Signed by both authorized official persons.
1.2.5. Effective communication with the NIHS.	▪ Documentation of official correspondence exchanged between the institution and the NIHS, such as letters, emails, or memoranda. ▪ Records of meetings or teleconferences held between the institution and representatives from the NIHS. ▪ Evidence of timely responses to requests for information or clarification from the NIHS. ▪ Documentation of any feedback or guidance provided by the NIHS to the institution.

	▪ Records of institutional compliance with any directives or recommendations issued by the NIHS. ▪ Reports or assessments evaluating the effectiveness of communication channels between the institution and the NIHS. ▪ Testimonials or statements from institutional representatives regarding their experiences with communication and collaboration with the NIHS. ▪ Any formal agreements or contracts between the institution and the NIHS outlining communication expectations and responsibilities.

Component 1.3. Governance Processes

Accreditation Requirements	Evidence guidelines
1.2.1. Availability of policy/manual for residency training.	▪ Provide copy of residency training manual.
1.2.2. Availability of financial plan and budgeting for residency.	The following are some types of evidence that can be submitted: **Financial Documentation** ▪ Annual Budgets: annual budgets specifying allocations for various activities and resources within the residency/ fellowship program. ▪ Multi-Year Financial Forecasts: long-term financial projections showing expected income and expenditure over multiple years. ▪ Audited Financial Statements: official financial statements, including balance sheets, income statements, and cash flow statements, verified by an external auditor. ▪ Interim Financial Reports: periodic financial reports providing updates on financial performance between annual audits. ▪ Evidence of funding sources such as grants, endowments, donations, and institutional support, including contracts or agreements with funding agencies or sponsors. **Policies and Procedures** **Financial Policies:** ▪ Written policies and procedures governing budgeting, financial planning, and expense management within the residency program. ▪ Guidelines outlining the oversight and management of financial resources. **Institutional Support:**

	▪ Letters of commitment or support from institutional leadership (e.g., deans, financial officers) affirming resource allocation for the residency program. ▪ Memoranda of understanding or agreements with affiliated institutions or hospitals that provide financial support. **Audit and Review Reports** ▪ Internal or External Audit Reports. ▪ Assessments by accrediting bodies or third-party financial consultants regarding the program's financial stability. ▪ Minutes from meetings where financial plans and budgets are discussed and approved.
1.2.3. Quality assurance (QA) system and plan for residency.	▪ Detailed QA plan outlining objectives, methods, and procedures for monitoring and improving the quality of the residency program. ▪ Written policies and procedures that govern QA activities, including how issues are identified, addressed, and monitored. **Resident/fellow Performance Evaluations:** ▪ Regular evaluations of resident/fellow performance, including feedback from supervisors and peers. ▪ Summative and formative assessment records. **Program Evaluations:** ▪ Periodic evaluations of the residency program, including curriculum, faculty, and overall program effectiveness. ▪ Surveys and feedback from residents/fellows and faculty. **Clinical Competency Committee (CCC) Reports:**

	▪ Reports from the CCC detailing resident/fellow progress, milestones, and areas for improvement. **Quality Metrics:** ▪ Data on key quality indicators such as patient outcomes, resident/fellow satisfaction, and program completion rates. ▪ Benchmarks and comparisons with national or institutional standards. **Survey Results:** ▪ Results from surveys conducted among residents/fellows, faculty, and other stakeholders regarding the quality of the residency/fellowship program. **Improvement Plans:** ▪ Documentation of action plans for addressing identified issues and improving program quality. ▪ Records of implemented improvements and their outcomes. **Accreditation Review Reports:** ▪ Reports from accrediting bodies on the residency program's compliance with QA standards and recommendations for improvement. **QA Committee Meeting Minutes:** ▪ Minutes from meetings of QA committees or similar bodies discussing quality issues and initiatives. **Faculty Development Programs:** ▪ Records of training and development programs for faculty aimed at improving teaching and assessment skills. **Resident/fellow Orientation and Training:** ▪ Documentation of orientation and ongoing training for residents/fellows on QA processes and expectations. **External QA Audits:**

	▪ Reports from external audits or reviews assessing the quality assurance system and its effectiveness. **Peer Reviews:** ▪ Reviews and evaluations conducted by peers from other residency programs or institutions. **Incident Reports:** ▪ Documentation of any incidents, complaints, or adverse events and the actions taken in response. **Complaint Resolution Records:** ▪ Records of complaints from residents/fellows or faculty and the steps taken to resolve them.

Domain 2: Training environment

Component 2.1. Physical setting and infrastructure

Accreditation Requirements	Evidence guidelines
1.2.1. Adequate clinical space, patient load, with good case mix.	**Clinical Space** ▪ Floor plans and layouts of clinical spaces, showing designated areas for patient care, resident/fellow work, and teaching activities. ▪ Photos or videos of clinical spaces demonstrating their adequacy and functionality. ▪ Documents showing the capacity of clinical spaces, such as the number of examination rooms, operating theaters, and patient beds. **Patient Volume Data:** ▪ Statistical reports showing the number of patients seen in various clinical settings (e.g., outpatient, inpatient, emergency) over a specified period. ▪ Trends in patient volume to demonstrate consistent and adequate patient load. **Case Mix:**

	▪ Reports detailing the case mix index, which measures the diversity and complexity of patient cases handled by the residency program. **Clinical Case Logs:** ▪ Logs maintained by residents/fellows documenting the types of cases they have managed, including case complexity and variety. ▪ Summaries of procedural and diagnostic experiences.
1.2.2. Adequate communication resources, technological support, information system e.g. databases.	▪ List of communication resources. ▪ Technological support: procedures, IT system. ▪ Information systems and databases: system documentation.
1.2.3. Adequate educational space.	Adequate educational space, including: ▪ Classrooms, conference and seminar rooms, and space for small group training activities in addition to services and break area. ▪ Space and infrastructure for practical labs, simulation, and library. ▪ Office spaces for training management and administrative personnel.
1.2.4. Adequate patient support services: peripheral intravenous access placement, phlebotomy, laboratory, and transporter services.	▪ Written policies and procedures for IV placement, phlebotomy, lab, and transport services. ▪ Protocols for staff training and quality assurance. ▪ Records of staff qualifications, certifications, and training. ▪ Inventory lists of needed equipment and supplies. ▪ Patient feedback on service experiences. ▪ Documentation of performance improvement projects. ▪ Reports on outcomes and service delivery changes.

1.2.5. Adequate laboratory, pathology, and radiology services in place to support timely and quality patient care.	▪ List of available resources.
1.2.6. Availability of medical records system that documents the course of each patient's illness, as well to support quality patient care, residents'/fellows' education, and quality assurance activities, and to provide a resource for scholarly activity.	▪ Screenshot form medical records system.
1.2.7. Access to appropriate food service 24 hours a day.	▪ This will be observed during the site visit.
1.2.8. The availability of adequate and appropriate call rooms or sleeping quarters that are safe, quiet, and private	▪ List of number of on call rooms or sleeping quarters that are safe, quiet, and private.
1.2.9. The availability of appropriate security and personal safety measures at all locations including parking facilities, on-call quarters, hospital and institutional grounds, and related facilities.	▪ This will be observed during the site visit.

Component 2.2. Clinical governance/practices

Accreditation Requirements	**Evidence guidelines**
2.1.1. Effective clinical governance e.g. clinical committees and policies**.**	▪ Records of clinical committee establishment and membership. ▪ Meeting minutes showing active participation. ▪ Documentation of quality improvement projects. ▪ Evidence of risk assessment and mitigation strategies. ▪ Incident reporting records and risk mitigation actions.
2.1.2. Adequate number and mix of clinical teams.	▪ Adequate number and mix of clinical teams required for service and training including professional mix, clinical knowledge and skills, and medical education expertise.

2.1.3. Appropriate education-service balance.	▪ Including arrangements to deal with peripheral activities such as patient support services and minor procedures (such as phlebotomists, nursing for intravenous medication etc.) by cadres other than the residents/fellows.
2.1.4. Appropriate diversity of training experience, e.g. different levels of services.	▪ Curriculum manual/block diagram. ▪ This will be observed during the site visit.
2.1.5. SI and participating sites are accredited by the Joint Commission International (JCI) or by another entity with reasonably equivalent standards.	▪ Official accreditation certificates issued by JCI or another accrediting entity with equivalent standards.

Component 2.3. Learning/training resources

Accreditation Requirements	Evidence guidelines
2.3.1. Sufficient equipment and supplies for learning e.g. audio-visual aids, computers, data-show, laptop, white board, etc.	▪ Lists detailing the available equipment and supplies for learning purposes, including audio-visual aids, computers, data projectors, laptops, whiteboards, etc.
2.3.2. Adequate IT infrastructure and systems.	▪ Existence of adequate information and communication technology (ICT) infrastructure and systems including servers, computer equipment, and software enabling technology-enhanced learning (TEL) and a website or webpage dedicated to residency training.
2.3.3. Access to specialty-/subspecialty specific and other appropriate reference material in print or electronic format. (Including electronic medical literature databases with search capabilities).	▪ List of appropriate reference material in print or electronic format.
2.3.4. Adequate setup and facilities for research.	▪ Lists detailing the equipment available for research purposes, including laboratory instruments, tools, and machinery. ▪ Photos/videos of research lab.

Component 2.4. Positive learning culture

Accreditation Requirements	Evidence guidelines
2.3.1. Flexible collegial environment for learning e.g. reward system and recognition.	▪ Present evidence of established reward systems, like incentive programs or awards, designed to recognize and incentivize collaborative learning efforts. ▪ Gather feedback from learners and faculty on the institution's collegial environment, particularly regarding flexibility, collaboration, and recognition.
2.3.2. Policy and process for complaints and appeal by which individual residents/ fellows can address concerns in a confidential and protected manner.	▪ Written policies detailing the complaint and appeal process for residents/fellows, including how concerns are raised and resolved. ▪ Procedural documentation outlining the steps for lodging complaints or appeals, along with response timelines and escalation paths. ▪ Logs or databases recording complaints and appeals, showing the nature of concerns and resolutions. ▪ Communication records between residents/fellows, PDs, and authorities during the complaint process.

Domain 3: Residents/fellows

Component 3.1. Recruitment and deployment

Accreditation Requirements	Evidence guidelines
2.3.1. Policy on residents'/fellows' eligibility and selection is available.	▪ Copy of the policy regarding the eligibility and selection of residents/fellows.
2.3.2. Participation in transparent match system.	▪ Documentation outlining internal policies and procedures related to participation in the match system, including guidelines for applicants and PDs.
2.3.3. Policy on residents'/fellows' appointment (contracts) and recruitment is available.	▪ Copy of resident'/fellows' contract.

2.3.4. Hospital and GME orientation process in place.	▪ GME orientation plan/presentation.
2.3.5. Residents/fellows participate in an educational program regarding physician impairment, including substance abuse and sleep deprivation.	▪ Onboarding orientation schedule.

Component 3.2. Competency acquisition

Accreditation Requirements	Evidence guidelines
2.3.1. Supervision policy to ensure provision of safe and effective patient care and educational needs of residents/fellows.	▪ Copy of supervision policy.
2.3.2. Residency/fellowship manuals addressing curriculum of training.	▪ Copy of residents/fellows training manual.
2.3.3. Mechanism for assigning progressive responsibility appropriate to residents'/fellows' level of education, competence, and experience.	▪ Copies of written policies and procedures outlining the framework for assigning progressive responsibility based on residents'/fellows' education, competence, and experience levels. ▪ Feedback from supervising faculty or preceptors regarding residents'/fellows' performance and readiness for increased responsibility. ▪ Performance evaluations are conducted periodically to assess residents'/fellows' progress and readiness for additional responsibilities. ▪ Documentation tracking residents'/ fellows' progression through various levels of responsibility over time.
2.3.4. Evaluation policy addressing formative assessment.	▪ Copy of the evaluation policy addressing formative assessment. ▪ Samples of evaluation tools, rubrics, or criteria used for formative assessment as per the policy.
2.3.5. Mechanism/policy for resident/ fellow mentorship is available.	▪ Mentorship policy. ▪ List of mentors and mentees.

	▪ Surveys, evaluations, or feedback forms completed by mentors and mentees, assessing the effectiveness of the mentorship program and the support provided.

Component 3.3. Training procedures

Accreditation Requirements	Evidence guidelines
2.3.1. Residents'/fellows' promotion and graduation criteria in alignment with NIHS bylaws.	▪ Copy of residents'/fellows' promotion criteria.
2.3.2. Participation of residents/fellows in patient safety and quality of care education.	▪ Documentation of residents'/fellows' particular care improvement initiatives aimed at enhancing patient safety and quality-of-care delivery within the institution. ▪ Reports or documentation of residents'/ fellows' involvement in patient safety incident reporting, root cause analyses, and implementation of corrective actions.
2.3.3. Mechanisms to ensure compliance on policies and procedures addressing duty hours.	▪ Duty hours policy. ▪ Duty hour logs. ▪ Documentation of mechanisms for monitoring compliance with duty hour policies, like electronic timekeeping, audits, or surveys. ▪ Reports summarizing compliance with duty hour policies, including non-compliance instances and corrective actions.
2.3.4. Procedures for residents'/fellows' transfer, freezing and withdrawal.	▪ Written policies outlining the process for residents'/fellows' transfer, freezing, and withdrawal, including eligibility, notification, and documentation. ▪ Transfer agreements or contracts between sending and receiving institutions. ▪ Records of freeze requests and their approvals or denials.

	▪ Records of withdrawal requests, including exit interview documentation and completion procedures.
2.3.5. Policy for leave of absence.	▪ Policy for leaves of absence. ▪ Leave tracking system.

Component 3.4. Resident support and growth

Accreditation Requirements	Evidence guidelines
2.3.1. Procedures to manage other learners.	▪ Policy and procedures for managing other learners.
2.3.2. Access to learning resources and support.	▪ List of learning resources. ▪ Screen shot from online systems.
2.3.3. Residents/fellows participate on committees and councils whose actions affect their education and/or patient care.	▪ Lists showing residents/fellows as members of relevant committees and councils.
2.3.4. Forum for residents/fellows to communicate and exchange information on their educational and work environments, their programs, and other resident/fellow issues.	▪ Screenshots or records of online platforms or forums (e.g., email groups, discussion boards) used by residents/fellows for communication. ▪ Documentation of agendas and minutes from regular meetings where residents/fellows discuss educational and work environment issues.
2.3.5. Provision for leadership and career progression.	▪ Documentation of leadership training programs for residents/fellows including schedules, curricula, and attendance records. ▪ Details of mentorship programs pairing residents/fellows with experienced leaders for career guidance. ▪ Records of career development workshops on networking, job search strategies, CV writing, and interview preparation. ▪ Lists of resident/fellow leadership positions (e.g., chief resident roles) and descriptions of their responsibilities.

	▪ Individual development plans (IDPs) outlining goals and steps for achieving leadership roles.
2.3.6. Procedures for counselling and wellbeing.	▪ Written policies and procedures outlining counseling and wellbeing services. ▪ Documentation of career counseling services, including schedules and feedback forms. ▪ Schedules of wellbeing programs, workshops, or activities promoting mental health. ▪ Information on accessing counseling and wellbeing services (brochures, website links, contact details). ▪ Feedback forms or survey results on resident/fellow satisfaction with counseling and wellbeing services.
2.3.7. Policy to mitigate the risk of reduction and closure of programs and addresses administrative support for GME programs in the event of a disaster or interruption in patient care (should include assistance for continuation of resident/fellow assignments).	▪ Policy outlining procedures to mitigate program risks and provide administrative support during disasters. ▪ Disaster plans ensuring continuation of resident/fellow assignments. ▪ Agreements with other institutions for resident/fellow reassignment during disruptions.

Domain 4: Faculty and administrative staff

Component 4.1. Scope and Recruitment

Accreditation Requirements	Evidence guidelines
2.3.1. Presence of program organizational structure to support the residency training e.g. PD, APD, Faculty (core and non-core; physician and non-physician), coordinator etc.	▪ Organizational chart detailing program structure, including PD, APD, core and non-core faculty, coordinators, and other roles. ▪ Job descriptions for each position, outlining responsibilities and qualifications. ▪ Appointment letters confirming roles for PD, APD, faculty, coordinators, and staff.

	▪ Rosters listing faculty specialties, academic affiliations, and clinical roles.
2.3.2. Availability of criteria for faculty eligibility and selection.	▪ Faculty eligibility and selection criteria.
2.3.3. Procedure for recruitment and job description.	▪ Procedure for recruiting faculty. ▪ Faculty job descriptions.
2.3.4. Hospital and GME orientation process in place e.g. faculty development training.	▪ Faculty orientation schedule/ presentation. ▪ Faculty development training schedule. ▪ Attendance records.

Component 4.2. Support and growth of training team

Accreditation Requirements	Evidence guidelines
2.3.1. Provision for time, space, and equipment.	▪ List of core faculty with allocated FTE. ▪ List of equipment.
2.3.2. Procedures for participation of faculty in evaluation and development of the residency program e.g. participation in program committees.	▪ Records showing faculty membership in program committees. ▪ Faculty evaluation forms. ▪ Meeting minutes.
2.3.3. Existing faculty development program.	▪ Faculty development training schedule. ▪ Attendance records.
2.3.4. Procedure in place for career progression and recognition.	▪ Policy for Rewarding system. ▪ Examples of rewarding initiatives and career progression plans.

Component 4.3. Performance management of training team

Accreditation Requirements	Evidence guidelines
2.3.1. Performance appraisal system in place.	▪ Faculty annual appraisal form.
2.3.2. Procedures to support the faculty to balance between teaching and clinical activities.	▪ This will be verified during the site visit.
2.3.3. The availability of institutional grievance policy including appeal procedure.	▪ Faculty grievance policy.

Domain 5: Continuous improvement and innovation

Component 5.1. Internal review

Accreditation Requirements	Evidence guidelines
2.3.1. Existing policy and process for internal review.	▪ Internal review policy.
2.3.2. Issuance of internal review report by the internal review committee.	▪ Internal review report.
2.3.3. Issuance of action plan for improvement by the reviewed program to be supported and approved by the GMEC.	▪ Improvement action plan.
2.3.4. Periodicity of internal review is observed.	▪ Documented schedules for internal reviews within the residency program. ▪ Reports detailing findings, recommendations, and actions from internal reviews. ▪ Meeting minutes documenting discussions and planning of internal reviews.

Component 5.2. Quality improvement culture and system

Accreditation Requirements	Evidence guidelines
2.3.1. System for quality assurance in place.	▪ Policies outlining quality assurance processes, responsibilities, and assessment methods. ▪ Documentation of quality improvement projects, including plans and outcomes. ▪ Lists of quality indicators and metrics for program assessment. ▪ Tools for data collection and analysis related to program quality. ▪ Records of training on quality assurance for faculty, staff, and residents/fellows. ▪ Feedback from stakeholders on program quality and effectiveness.

	▪ Reports from external reviewers assessing program quality and compliance.
2.3.2. Documentation and reporting system in place e.g. clinical incidents reports, complaints, audits, tracers etc.	▪ Clinical incident reports documenting incident details, actions taken, and outcomes. ▪ Complaint records detailing complaint nature, investigation findings, and resolutions.
2.3.3. Quality indicators reported across many clinical and administrative domains.	▪ Lists of quality indicators and metrics for program assessment.

Component 5.3. Change and innovation

Accreditation Requirements	**Evidence guidelines**
5.3.1. Existing resources for renewal and innovation.	▪ Documentation of resources for renewal and innovation initiatives, including funds, equipment, facilities, and personnel. ▪ Records of past and ongoing innovation projects. ▪ Partnerships with external organizations or academic institutions supporting program innovation. ▪ Training programs for faculty, staff, and residents/fellows to enhance innovation skills. ▪ Success stories demonstrating effective resource utilization for program renewal and innovation.
5.3.2. Socially responsive residency training.	▪ Documentation of resident/fellow involvement in community outreach programs, volunteer activities, or initiatives addressing local health disparities. ▪ Records demonstrating the integration of social determinants of health and health equity principles into the residency/ fellowship curriculum, such as

	didactic sessions, workshops, or experiential learning opportunities. ▪ Documentation of collaborative projects or experiences involving residents/ fellows, other healthcare professionals, and community stakeholders to address social determinants of health ▪ Scholarly work or research projects conducted by residents/fellows focusing on social determinants of health, health disparities, or community-based interventions. ▪ Feedback from patients, community members, faculty, and other stakeholders on the impact of resident/fellow training initiatives on community health and well-being. ▪ Program policies or mission statements reflecting a commitment to socially responsive training and addressing health inequities.
5.3.3. Existence of innovative initiatives and practices.	▪ Documentation of innovative projects. ▪ Resident/fellow involvement in innovative initiatives. ▪ Recognition for innovative practices. ▪ Plans for continuous improvement and adaptation.

Glossary of Terms

TERM	DEFINITION
Clinical governance	The system of structures, relationships, and processes involved in continuously overseeing and safeguarding high standards of clinical services.
Continuous improvement	A systematic approach to continuously review, update, and improve residency training experience to enhance quality and ensure effective outcomes.
Designated Institutional Official	The designated institutional official is the qualified person appointed by the sponsoring institution as authorized and

	responsible for leadership and management for all aspects pertaining to the residency and fellowship training.
Graduate Medical Education Committee (GMEC)	The committee appointed by the sponsoring institution to support the role of the DIO in overseeing all aspects pertaining to residency training.
Clinical Competency Committee	The specific committee appointed by the PD to assess and evaluate the performance of residents/fellows within the specialty/subspecialty program.
Faculty	The entire teaching workforce responsible for educating residents/fellows.
Fellow	Individual candidates enrolled for training in a subspecialty program leading to fellowship qualification.
Formative evaluation	Monitoring resident/fellow training and providing ongoing feedback to improve learning.
Full Time Equivalent	The FTE refers to calculation of the time dedicated for residency/fellowship training management or delivery as part of the full time allotted to work (ideally 40 hours per week).
Internal review	The internal evaluation conducted within the training program to identify and act on strengths and weaknesses/areas for improvement of residency/fellowship training.
Participating site	An organization (hospital, health center, health facility, etc.) providing educational experiences or educational assignments/rotations for residents/fellows through arrangement with the sponsoring institution. A participating site can be within the sponsoring institution's country or international.
Program coordinator	The program coordinator is a qualified administrative staff member designated with authority to assist the PD in managerial and logistical coordination.
rogram director (PD)	The PD is the qualified person designated with authority, responsibility, and accountability of managing and coordinating a specific (specialty) residency/fellowship program.
Program Evaluation Committee	The specific committee appointed by the PD to assess and evaluate the whole business of the specialty program.
Residents	Individual candidates enrolled for training in a residency.
Sponsoring institution	The organization or entity (Hospital, group of health facilities, a health department, a health system, etc.) that

	assumes the ultimate responsibility for a residency/fellowship training experience. The sponsoring institution has the primary responsibility of applying for accreditation and committing resources and support to comply with accreditation requirements.
Training governance	The system of structures, relationships, and processes involved in oversight and maintenance of high-quality residency training experience.
Training center	The hospital or group of health facilities accredited to host residency/fellowship training programs
Training environment	The diverse context for trainee development, including physical locations, learning resources, clinical experiences, and institutional culture.
The training team	The totality of faculty and administrative personnel involved in the delivery and coordination of actual residency/fellowship training activities. The faculty represent the mainstay discipline-specific personnel entrusted with the supervision of trainees. Other faculty are personnel from other disciplines taking part in training activities. Administrative personnel include administrators, logistic staff, and secretaries.

References:

- NIHS Institutional Accreditation requirements