NATIONAL INSTITUTE FOR HEALTH SPECIALITIES

NIHS Program Requirements for Specialty Training in Mental Health Nursing

The Emirati Board in Mental Health Nursing Program is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. The Program must demonstrate substantial compliance with the Common and specialty-specific Program Requirements.

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophical statements are not program requirements and are therefore not citable.

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Introduction

Int. A. Preamble

The UAE National Strategy for Nursing/Midwifery: A Roadmap 2026 focuses on human capital development highlighting the need to drive excellence in nursing/midwifery practice. One of the initiatives to achieve this is developing and implementing nursing/midwifery specialist programs.

Residency is defined as the stage of postgraduate training and education leading to a qualification of independent practice in a core specialty (NHIS 2020:4). Essentially the purpose of the residency program is to equip nurses and midwives with the knowledge, attitude, and skills essential for specialist practice (Raman et al., 2019).

Int. B. Goals and Objectives

The goal of the program is to raise the quality of mental healthcare through expanded knowledge and clinical expertise of registered nurses in mental healthcare.

The program objectives are:

- To develop knowledge, desirable attitude, and application of skill in the systematic and comprehensive assessment, caring and record keeping for consumers of mental healthcare services as autonomous and responsible nurses throughout the lifespan at all levels of care.
- To apply critical thinking skills using a health systems approach to problem- solve and make complex decisions in mental healthcare contexts.
- To lead in the design, implementation, and evaluation of quality improvement processes in mental healthcare.
- To lead registered nurses as best practice and management role models in the delivery of mental health care.
- To influence mental healthcare delivery through engagement in policy development at an institutional, national, or international level.
- To apply teaching and learning strategies for own and staff development that can be implemented to support and enhance in the field of mental health care.

The clinical competence of nurses plays a significant role in the quality of nursing care provision and patient outcomes and the clinical competence of nurses and midwives is inextricably linked to the foundational knowledge of the specialist area which is continuously strengthened through lifelong learning by practitioners.

The need for the mental healthcare nursing program is confirmed by the following information:

- Recognition of mental health as a prime pillar of The UAE National Strategy for Wellbeing.
- The launch of the National Policy for the Promotion of Mental Health to strengthen

multi-sectoral collaboration in mental health.

The UEA number of community-based mental health services per 100 000 population has increased from 0.37 in 2017 to 1.17 in 2020 (WHO, 2020)

Int. C. Definition of Specialty

Mental health nursing science is a well-defined base of knowledge within the overall discipline of nursing. This program prepares nurses with specialist knowledge and skills to address the mental healthcare needs of individuals, families, groups, and populations throughout the lifespan.

Int. D. Length of Educational Program

The length of the mental health nursing residency program must be at least continuous 24 months in total. (Core)

For residents with no prior clinical experience in mental health settings, the length of the mental health nursing residency program may be extended to be at least continuous 15 months in total; including an initial minimum of 3-months onboarding program to general mental health nursing.

I. Oversight

I.A Sponsoring Institution

The Sponsoring Institution is the entity that assumes the ultimate financial and academic responsibility for a program of graduate nursing education, consistent with the NIHS Institutional Requirements.

The Sponsoring Institution must be the primary clinical defined as the most utilized rotation site of clinical activity for the program.

I.A.1. The program must be sponsored by one NIHS-accredited Sponsoring Institution. (Core)

I.A.2. At least one site must be assigned for training to assume responsibility for the mental health residency program. (Core)

I.A.3. A letter of commitment, the need for the program and pledged support must be available. (Core)

I.A.4. Timely and effective internal relationships with all program teams and stakeholders must be evidenced by documentation of meetings and protocols for communication. (Core)

IB. Participating Sites

A participating site is an entity that provides educational experiences or educational assignments/rotations for residents.

I.A.5. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)

I.A.6. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)

I.A.6.a) The PLA must:

I.B.2.a)(1) be renewed at least every 5 years; (Core)

I.B.2.a)(2) be approved by the designated institutional official (DIO); (Core)

I.B.2.a)(3) specify the duration and content of the educational experience; (Core)

I.B.2.a)(4) state the policies and procedures that will govern resident education during the assignment; (Core)

I.B.2.a)(5) identify the faculty members who will assume educational and supervisory responsibility for residents; (Core)

I.B.2.a)(6) specify the responsibilities for teaching, supervision, and formal evaluation of residents. (Core)

I.A.7. The program must monitor the clinical learning and working environment at all participating sites. (Core)

I.A.7.a) At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)

I.A.8. Resident assignments away from the Sponsoring Institution should not prevent residents' regular participation in required didactics. (Core)

I.C Resources

I.A.9. The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. including lecture rooms, skills labs, recreation, and gender-sensitive

amenities. (Core)

I.A.10. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for (Core)

I.A.10.a) access to food while on duty; (Core)

I.A.10.b) security and safety measures appropriate to the participating site. (Core)

I.A.11. Residents must have ready access to mental health nursing and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)

I.A.12. The program's educational and clinical resources must be adequate to support the number of residents appointed to the program. (Core)

I.A.12.a) A sufficient population of patients with a variety of demographic, socioeconomic backgrounds, and disease patterns to allow for effective and comprehensive training experiences. (Core)

I.A.12.b) Residents must be provided with software resources, training and technical support for research, scholarly activities and presentations or manuscripts and other written assignments. (Core)

I.A.13. The program must provide a positive learning environment in a flexible, compassionate culture promoting teamwork and interdisciplinary and interprofessional learning environment. (Core)

I.E Other Learners and Other Care Providers

The presence of other learners and other care providers, including, but not limited to, residents from other programs (including medical) must enrich the appointed residents' education. (Core)

I.A.14. The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and to the graduate medical education committee (GMEC). (Core)

II. Personnel

II.A Program Director

II.A.1. There must be one faculty member appointed as program director

for the mental health program with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)

II.A.1.a) The Sponsoring Institution's GMEC must approve a change in program director. (Core)

II.A.1.b) The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)

II.A.1.c) The Program Director position shall be assumed for a minimum of 3 years to ensure continuity. (Core)

II.A.2. At a minimum, the program director must be provided with the salary support required to devote 50 percent FTE of non-clinical time to the administration of the program. (Core)

II.A.2.a) Additionally, the program director must be provided with:

II.A.2.a)(1) Workspace, equipment and technology, administration support, resources. (Core)

II.A.2.a)(2) A stated clear job description defining expectations and accountability and reporting structure. (Core)

II.A.2.a)(3) An Associate Program Director to support the management of the residency program. (Core)

II.A.3. Qualifications of the program director:

II.A.3.a) must include knowledge and/or experience in adult learning principles and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Central Accreditation Committee; (Core)

II.A.3.b) must be licensed as a mental health nurse specialist and hold at least a graduate qualification in nursing mental health. (Core)

II.A.3.c) must include appropriate staff appointment; (Core)

II.A.3.d) must include ongoing clinical activity. (Core)

II.A.4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)

II.A.4.a) The program director must:

II.A.4.a)(1) be a role model of professionalism; (Core)

II.A.4.a)(2) design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)

II.A.4.a)(3) administer and maintain a learning environment conducive to educating the residents. in each of the Competency domains; (Core)

II.A.4.a)(4) develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the residency program education and at least annually thereafter; (Core)

II.A.4.a)(5) have the authority to approve and/or remove program faculty members for participation in the residency program education at all sites; (Core)

II.A.4.a)(6) have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)

II.A.4.a)(7) submit accurate and complete information required and requested by the DIO, GMEC, and NIHS; (Core)

II.A.4.a)(8) provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)

II.A.4.a)(9) ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a resident; (Core)

II.A.4.a)(10) ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)

II.A.4.a)(11) document verification of program completion for all graduating residents; within 30 days; (Core)

II.A.4.a)(12) obtain review and approval of the Sponsoring Institution's DIO before submitting information, as required in the Institutional Requirements and outlined in the NIHS guidelines to the Program Requirements. (Core)

II.A.4.a)(13) ensure implementation of fair treatment of faculty and administrative staff supported by an appeal process to allow objective and timely response. (Core)

II.A.4.a)(14) ensure implementation of procedures for training of faculty and administrative staff and address concerns timely and fairly. (Core)

II.A.5. Associate Program Director (APD):

II.A.5.a) The sponsoring institution must appoint an Associate Program director to support the PD by actively participating in administrative and educational activities (Core)

II.A.5.b) Sponsoring institution to provide APD with 0.3 FTE (or 12 hours per week) of protected time for education and program administration, (Core)

II.A.5.c) APD should assume the role for a duration suitable for ensuring program continuity and stability. (Core)

II.A.5.d) The designated APD should possess a minimum of graduate degree in nursing, a valid RN license and should have educational qualifications or experience in adult learning principles. (Core)

II.B Faculty

Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. By employing a scholarly

approach to patient care, faculty members, through the education system, improve the health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.

II.A.6. At each participating site, there must be enough faculty members with competence to instruct and supervise all residents at that location. (Core)

II.B.1.a) The ratio of all faculty to residents must be a minimum of 1:1. (Core)

II.A.7. Faculty members must:

II.A.7.a) be role models of professionalism; (Core)

II.A.7.b) demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care; (Core)

II.A.7.c) demonstrate a strong interest in the education of residents; (Core)

II.A.7.d) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)

II.A.7.e) administer and maintain an educational environment conducive to educating residents; (Core)

II.A.7.f)regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Core)

II.A.7.g) At least one member of the faculty should support resident scholarly activities. (Core)

II.A.8. Faculty Qualifications

II.A.8.a) Faculty must be mental health specialist nurses that are licensed to practice and hold appropriate institutional appointments. (Core)

II.A.8.b) Administrative staff must have qualifications and

experience suitable for their roles. (Core)

II.A.9. Core Faculty

Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)

II.A.9.a) Core faculty members must be designated by the program director. (Core)

II.A.9.b) Core faculty members must complete the annual NIHS Faculty Survey. (Core)

II.C Program Coordinator

II.A.10. There must be a program coordinator. (Core)

II.A.11. At a minimum, the program coordinator must be provided with adequate time for the administration of the program. (Core)

III. Resident Appointments

III.A Eligibility Requirements

III.A.1. An applicant must meet the following qualifications to be eligible for appointment to a NIHS-accredited program: (Core)

III.A.1.a) Refer to NIHS criteria included in the Training Bylaw. (Core)

III.A.1.b) Registered nurses who have completed a Bachelor of Science in Nursing (BSN) and a recognized transition-to-practice residency program. (Core)

III.A.1.c) Registered nurses holding a Bachelor of Science in Nursing (BSN), with at least one year of full-time clinical experience and a current license to practice. (Core)

III.B Number of Residents

III.A.2. The program director must not appoint more residents than approved by the Central Accreditation Committee. (Core)

III.A.3. All changes in resident complement must be approved by the NIHS Central Accreditation Committee. (Core)

III.A.4. The number of residents appointed to the program must not

exceed the program's educational and clinical resources. (Core)

IV. Educational Program

The NIHS accreditation system is designed to encourage excellence and innovation in nursing education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful nurses who provide compassionate care.

IV.A Curriculum Components

The core curriculum must include monthly didactic sessions including ward rounds, clinical meetings, case presentations, morbidity and mortality reviews, lectures, journal clubs and evidence reviews, multidisciplinary meetings, seminars, workshops, videos, demonstrations, simulation, standardized patient activities, reflective and interactive activities. (Core)

The Educational Curriculum must contain the following educational components: (Core)

IV.A.1. A set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates; (Core)

IV.A.2. There must be structured clinical experience (with the curriculum contributing to the overall goal of the program incorporating exposure

to acute emergency and acute in- patient care, chronic care, community, and primary healthcare services, psychogeriatric, clinical psychology and counseling services, substance use services, working with families and children. (Core)

IV.A.3. Overall educational goals for the program must exist that is communicated to residents and faculty. (Core)

IV.A.4. Competency-based goals and objectives for each educational experience are designed to promote progress on a trajectory to autonomous practice and must be available for assignments at each level. (Core)

IV.A.5. Residents must be provided with increasing responsibility in patient care and management, supervision, teaching, and administration according to the training stage. (Core)

IV.A.6. Residents must be equipped with essential research principles and competencies and residents and faculty must participate in research

and scholarly activities. (Core)

IV.A.7. The implementation of guidelines on residents' education-service balance must be available consisting of at least 600 hours for knowledge development, 600 hours skills development and placement in clinical practice for a minimum of 250 hours. (Core)

IV.A.8. Diversity of training experiences for residents must be made available through rotations through different services providing mental healthcare services. (Core)

IV.A.9. Residents must be provided with protected time to participate in structured didactic activities. (Core)

IV.A.10. Didactic activities include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, case discussions, grand rounds, didactic teaching, journal clubs, and education in critical appraisal of medical evidence. (Core)

IV.B Competency for Mental Health Nurse Specialist

IV.A.11. Entry-to-Practice competencies for Nurse Specialist

Specialty background: *This document outlines the expected entry level competencies for Nurses Specialist**.***

This should guide the academic institutions on the outcomes that should be achieved for any Post graduate Nursing specialization.

These competencies are the benchmark for the knowledge, skills, and judgements individuals must demonstrate for safe, ethical, and effective Nurses specialist practice.

IV.A.11.a) Client Care

IV.B.1.a)(1) Client Relationship Building and Communication

The competent, entry-level nurse specialist uses appropriate communication strategies to create a safe and therapeutic environment for client care.

IV.B.1.a)(1)(a) Clearly articulate the role of the nurse specialist when interacting with the client. (Core)

IV.B.1.a)(1)(b) Use developmentally and culturally appropriate communication techniques and tools.

(Core)

IV.B.1.a)(1)(c) Create a safe environment for effective and trusting client interaction where privacy and confidentiality are maintained. (Core)

IV.B.1.a)(1)(d) Use relational strategies (e.g., open-ended questioning, fostering partnerships) to establish therapeutic relationships. (Core)

IV.B.1.a)(1)(e) Provide culturally safe care, integrating clients' cultural beliefs and values in all client interactions. (Core)

IV.B.1.a)(1)(f) Identify personal beliefs and values and provide unbiased care. (Core)

IV.B.1.a)(1)(g) Recognize moral or ethical dilemmas, and take appropriate action if necessary (e.g., consult with others, involve legal system). (Core)

IV.B.1.a)(1)(h) Document relevant aspects of client care in client record. (Core)

IV.B.1.a)(2) Assessment

The competent, entry-level Nurse Specialist integrates an evidence-informed knowledge base with advanced assessment skills to obtain the necessary information to identify client diagnoses, strengths, and needs.

IV.B.1.a)(2)(a) Establish the reason for the client encounter: (Core)

- Review information relevant to the client encounter (e.g., referral information, information from other healthcare providers, triage notes) if available.
- Perform initial observational assessment of the Client's condition.
- Ask pertinent questions to establish the context for client encounter and chief presenting issue.
- Identify urgent, emergent, and life-threatening situations.
- Establish priorities of client encounter.

IV.B.1.a)(2)(b) Complete relevant health history appropriate to the client's presentation: (Core)

- Collect health history such as symptoms, history of presenting issues, past medical and mental health history, family health history, pre-natal history, growth and development history, allergies, prescription and OTC medications, and complementary therapies.
- Collect relevant information specific to the client's psychosocial, behavioral, cultural, ethnic, spiritual, developmental life stage, and social determinants of health.
- Determine the client's potential risk profile or actual risk behaviors (e.g., alcohol, illicit drugs and/or controlled substances, suicide or self-harm, abuse, or neglect, falls, infections).
- Assess client's strengths and health promotion, illness prevention, or risk reduction needs.

IV.B.1.a)(2)(c) Perform assessment: (Core)

- Based on the client's presenting condition and health history, identify level of assessment (focused or comprehensive) required, and perform review of relevant systems.
- Select relevant assessment tools and techniques to examine the client.
- Perform a relevant physical examination based on assessment findings and specific client characteristics (e.g., age, culture, developmental level, functional ability).
- Assess mental health, cognitive status, and vulnerability using relevant assessment tools.
- Integrate laboratory and diagnostic results with history and physical assessment findings.

IV.B.1.a)(3) Diagnosis

The competent, entry-level Nurse Specialist is engaged in the diagnostic process and develops differential diagnoses through identification, analysis, and interpretation of findings from a variety of sources.

IV.B.1.a)(3)(a) Determine differential diagnoses for

acute, chronic, and life-threatening conditions: (Core)

- Analyze and interpret multiple sources of data, including results of diagnostic and screening tests, health history, and physical examination.
- Synthesize assessment findings with scientific knowledge, determinants of health, knowledge of normal and abnormal states of health/illness, patient and population level characteristics, epidemiology, health risks.
- Inform the client of the rationale for ordering diagnostic tests.
- Determine most likely diagnoses based on clinical reasoning and available evidence.
- Assume responsibility for follow-up of test results.
- Confirm most likely diagnoses.

IV.B.1.a)(3)(b) Explain assessment findings and communicate diagnosis to client: (Core)

- Explain the results of clinical investigations to client.
- Communicate diagnosis to client, including implications for short- and long-term outcomes and prognosis.
- Ascertain client understanding of information related to findings and diagnoses.

IV.B.1.a)(4) Management

The competent entry-level Nurse Specialist, based on assessment and diagnosis, formulates the most appropriate plan of care for the client, implementing evidence-informed therapeutic interventions in partnership with the client to optimize health.

IV.B.1.a)(4)(a) Initiate interventions for the purpose of stabilizing the client in urgent, emergent, and life-threatening situations (e.g., establish and maintain airway, breathing and circulation, suicidal ideation). (Core)

IV.B.1.a)(4)(b) Formulate plan of care based on diagnosis and evidence-informed practice: (Core)

- Determine and discuss options for managing the client's diagnosis, incorporating client considerations (e.g., socioeconomic factors, geography, developmental stage).
- Select appropriate interventions, synthesizing information including determinants of health, evidence-informed practice, and client preferences.
- Initiate an appropriate plan of care (e.g. non-pharmacological, pharmacological, diagnostic tests, referral).
- Consider resource implications of therapeutic choices (e.g. cost, availability).

IV.B.1.a)(4)(c) Provide pharmacological interventions, treatment or therapy: (Core)

- Counsel client on pharmacotherapeutics, including rationale, cost, potential adverse effects, interactions, contraindications, and precautions as well as reasons to adhere to the prescribed regimen and required monitoring and follow up.
- Establish a plan to monitor client's responses to Medication therapy.
- Apply strategies to reduce risk of harm involving controlled substances, including medication abuse, addiction, and diversion.

IV.B.1.a)(4)(d) Provide non-pharmacological interventions, treatments, or therapies: (Core)

- Select therapeutic options (including complementary and alternative approaches) as indicated by diagnosis based on determinants of health, evidence-informed practice, and client preference.
- Counsel client on therapeutic option(s), including rationale, potential risks and benefits, adverse effects, required after care, and follow-up.
- Order required treatments (e.g., wound care, phlebotomy).
- Discuss and arrange follow-up.

IV.B.1.a)(4)(e) Perform invasive and non-invasive procedures: (Core)

- Inform the client about the procedure, including rationale, potential risks and benefits, adverse effects, and anticipated aftercare and follow-up.
- Obtain and document informed consent from the client.
- Perform procedures using evidence-informed techniques as per regulations and scope of practice.
- Review clinical findings, aftercare, and follow-up.

IV.B.1.a)(4)(f) Provide oversight of care across the continuum for clients with complex and/or chronic conditions. (Core)

IV.B.1.a)(4)(g) Follow up and provide ongoing management: (Core)

- Develop a systematic and timely process for monitoring client progress.
- Evaluate response to plan of care in collaboration with the client.
- Revise plan of care based on client's response and preferences.

IV.B.1.a)(5) Collaboration, Consultation, and Referral

The competent, entry-level Nurse Specialist identifies when collaboration, consultation, and referral are necessary for safe, competent, and comprehensive client care.

IV.B.1.a)(5)(a) Establish collaborative relationships with healthcare providers and community-based services (e.g., school, police, child protection services, rehabilitation, home care). (Core)

IV.B.1.a)(5)(b) Provide recommendations or relevant treatment in response to consultation requests or incoming referrals. (Core)

IV.B.1.a)(5)(c) Identify need for consultation and/or referral (e.g., to confirm a diagnosis, to augment a

plan of care, to assume care when a client's health condition is beyond the nurse Specialist's individual competence or legal scope of practice). (Core)

IV.B.1.a)(5)(d) Initiate a consultation and/or referral, specifying relevant information (e.g., client history, assessment findings, diagnosis) and expectations. (Core)

IV.B.1.a)(5)(e) Review consultation and/or referral recommendations with the client and integrate into plan of care as appropriate. (Core)

IV.B.1.a)(6) Health Promotion

The competent, entry-level Nurse Specialist uses evidence and collaborates with community partners and other healthcare providers to optimize the health of individuals, families, communities, and populations.

IV.B.1.a)(6)(a) Identify individual, family, community and/ or population strengths and health needs to collaboratively develop strategies to address issues. (Core)

IV.B.1.a)(6)(b) Analyze information from a variety of sources to determine population trends that have health implications. (Core)

IV.B.1.a)(6)(c) Select and implement evidence-informed strategies for health promotion and primary, secondary, and tertiary prevention. (Core)

IV.B.1.a)(6)(d) Evaluate outcomes of selected health promotion strategies and revise the plan accordingly. (Core)

IV.A.11.b) Quality Improvement and Research

The competent entry-level Nurse Specialist uses evidence-informed practice, seeks to optimize client care and health service delivery, and participates in research.

IV.B.1.b)(a) Identify, appraise, and apply research, practice guidelines, and current best practice. (Core)

IV.B.1.b)(b) Identify the need for improvements in health service delivery. (Core)

IV.B.1.b)(c) Analyze the implications (e.g., opportunity costs, unintended consequences) for the client and/or the system of implementing changes in practice. (Core)

IV.B.1.b)(d) Implement planned improvements in healthcare and delivery structures and processes. (Core)

IV.B.1.b)(e) Participate in quality improvement and evaluation of client care outcomes and health service delivery. (Core)

IV.B.1.b)(f) Identify and manage risks to individuals, families, populations, and the healthcare system to support quality improvement. (Core)

IV.B.1.b)(g) Report adverse events to clients and/or appropriate authorities, in keeping with relevant legislation and organizational policies. (Core)

IV.B.1.b)(h) Analyze factors that contribute to the occurrence of adverse events and near misses and develop strategies to mitigate risks. (Core)

IV.B.1.b)(i) Participate in research. (Core)

IV.B.1.b)(j) Contribute to the evaluation of the impact of nurse Specialist practice on client outcomes and healthcare delivery. (Core)

IV.A.11.c) Leadership

The competent entry-level nurse specialist demonstrates leadership by using the nurse Specialist role to improve client care and facilitate system change.

IV.B.1.c)(1) Promote the benefits of the nurse specialist role in client care to other healthcare providers and stakeholders (e.g., employers, social and public service sectors, the public, legislators, policymakers). (Core)

IV.B.1.c)(2) Implement strategies to integrate and optimize

the Nurse Specialist role within healthcare teams and systems to improve client care. (Core)

IV.B.1.c)(3) Coordinate interprofessional teams in the provision of client care. (Core)

IV.B.1.c)(4) Create opportunities to learn with, from, and about other healthcare providers to optimize client care. (Core)

IV.B.1.c)(5) Contribute to team members' and other healthcare providers' knowledge, clinical skills, and client care (e.g., by responding to clinical questions, sharing evidence). (Core)

IV.B.1.c)(6) Identify gaps and/or opportunities to improve processes and practices, and provide evidence informed recommendations for change. (Core)

IV.B.1.c)(7) Utilize theories of and skill in communication, negotiation, conflict resolution, coalition building, and change management. (Core)

IV.B.1.c)(8) Identify the need and advocate for policy development to enhance client care. (Core)

IV.B.1.c)(9) Participate in program planning and development to optimize client care. (Core)

IV.A.11.d) Education

The competent, entry-level Nurse Specialist integrates formal and informal education into practice. This includes but is not limited to educating self, clients, the community, and members of the healthcare team.

IV.B.1.d)(1) Client, Community, and Healthcare Team Education

IV.B.1.d)(1)(a) Assess and prioritize learning needs of intended recipients. (Core)

IV.B.1.d)(1)(b) Apply relevant, theory-based, and evidence informed content when providing education. (Core)

IV.B.1.d)(1)(c) Utilize applicable learning theories, develop education plans, and select appropriate delivery methods, considering available resources (e.g., human, material, financial). (Core)

IV.B.1.d)(1)(d) Disseminate knowledge using appropriate delivery methods (e.g., pamphlets, visual aids, presentations, publications). (Core)

IV.B.1.d)(1)(e) Recognize the need for and plan outcome measurements (e.g., obtaining client feedback, conducting pre- and post-surveys). (Core)

IV.B.1.d)(2) Continuing Competence

IV.B.1.d)(2)(a) Engage in self-reflection to determine continuing education competence needs. (Core)

IV.B.1.d)(2)(b) Engage in ongoing professional development. (Core)

IV.A.12. Mental Health Nurse Specialist Competencies

Professional, Ethical and Legal Practice

IV.B.2.a)(1) Professional Practice

IV.B.2.a)(1)(a) Accept accountability for increased responsibility, including own professional judgment, actions, outcomes of care, ethical practice, and continued competence in accordance with legislation and policy frameworks (both nationally and internationally). (Core)

IV.B.2.a)(1)(b) Recognize and practice within the professional, ethical, and legal parameters of the Mental Health Nurse as a mental health care Specialist. (Core)

IV.B.2.a)(1)(c) Recognize its own level of competence and limitations to take action as a Mental Health Nurse. (Core)

IV.B.2.a)(1)(d) Collaborate with the mental health care user, his/her family (including significant others), the community and the multidisciplinary team to ensure a team-based approach and consult

with or refers to appropriate other aid sources when encountering situations beyond own competence and ensures implementation of evidence-based mental health care practice. (Core)

IV.B.2.a)(1)(e) Recognize and respect different levels of accountability for the range of available health care professionals, fostering professional autonomy. (Core)

IV.B.2.a)(1)(f) Lead and participate in activities related to improving access to the range of mental health care services required for effective specialist services. (Core)

IV.B.2.a)(1)(g) Engage in continuous professional development, utilizing formal and informal platforms, by reflecting and recognizing own level of competence and limitations; and seek development opportunities and record development activities to provide evidence of lifelong learning. (Core)

IV.B.2.a)(1)(h) Commit to the development of peers, students, and other categories of healthcare providers by creating a healthy practice environment that promotes and fosters professional growth and resilience. (Core)

IV.B.2.a)(1)(i) Actively participate in activities and affairs of professional associations and regulatory bodies to advocate for professional matters and mental health care (specifically mental health care nursing) in the development of legislation and policies, including the improvement of mental health care practices. (Core)

IV.B.2.a)(2) Ethical Practice

IV.B.2.a)(2)(a) Deliver mental health care in a manner that preserves and protects the autonomy, dignity, rights, values, beliefs and preferences of the mental health care Specialist, users and their family/significant others, and the community. (Core)

IV.B.2.a)(2)(b) Participate in ethical and legal debates concerning complex decisions and orders in the mental health setting, for example: involuntary patients and care of forensic mental health care users, vulnerable populations, and including research activities. (Core)

IV.B.2.a)(2)(c) Acknowledge the significance and contribution of the mental health care user (MHCU),the family/significant others and the community in ethical decision making in conjunction with the multidisciplinary team, .and assisting them to make informed decisions. (Core)

IV.B.2.a)(2)(d) Maintain and advocate for the autonomy and confidentiality of the MHCU and his/her family within the legal and ethical framework, to protect MHCU confidentiality and adhere to relevant legislation which governs the privacy, access, use, retention and disclosure of personal information. (Core)

IV.B.2.a)(2)(e) Intervene, in accordance with legislative guidance, in cases of illegal, unethical, or inappropriate behavior that expose the MHCU to risk. (Core)

IV.B.2.a)(2)(f) Participate in and advocate for the MHCU, family/ significant others, the community, and the profession in all aspects of decision making, especially in respect of ethical dilemmas, and serve as a mentor and role model by participating in the resolution of ethical and clinical dilemmas(Core)

IV.B.2.a)(2)(g) Advocate for Mental Health Nurses and other auxiliary staff in addressing risks and safety concerns in mental health settings, including the community; promoting advancement and positive practice environments, whilst recognizing limitations and scope of practice; and counteract the stigma of mental illness while creating awareness about the epidemic of mental illness. (Core)

IV.B.2.a)(2)(h) Identify, mitigate, and manage potential and actual medico-legal risks in the

mental health setting, and reporting thereof to the relevant authorities. (Core)

IV.B.2.a)(2)(i) Display sensitivity to cultural, professional, lifestyle and technological diversity within the multidisciplinary team and mental health/ illness continuum and promote cultural and lifestyle sensitive care. (Core)

IV.B.2.a) (2)(j) Maintain confidentiality and security of written, verbal, and electronic information acquired. (Core)

IV.B.2.a)(2)(k) Promote the recovery and the responsible re-integration of MHCUs back into the community. (Core)

IV.B.2.a)(3) Legal Practice

IV.B.2.a)(3)(a) Practice in accordance with professional and other relevant legislation applicable to mental health nursing and mental health care. (Core)

IV.B.2.a)(3)(b) Recognize and act upon legislation relating to the professional role and/or professional code of conduct. (Core)

IV.B.2.a)(3)(c) Practice in accordance with current mental health care policies and evidence-based procedural guidelines and protocols. (Core)

IV.B.2.a)(3)(d) Interpret and evaluate current regulations to develop or implement clinical practice guidelines and policies for situations of violence, neglect and abuse, and any other relevant emerging areas of identified need. (Core)

IV.B.2.a)(3)(e) Demonstrate knowledge of all relevant legislation (national and international) which may impact on mental health care nursing practice. (Core)

IV.B.2.a)(3)(f) Demonstrate knowledge of mental health legislation in terms of admission, transfer, discharge and rehabilitation under the Mental

Health Care Act No.17 of 2002. (Core)

Care Provision and Management

IV.B.2.b)(1) Health promotion and illness prevention

IV.B.2.b)(1)(a) Promote mental health in all settings through inter-sectoral collaboration and engagement, to create awareness and address issues such as minimizing stigma and discrimination, mental health literacy, mental wellbeing, healthy lifestyles, coping mechanisms and resilience, thereby building capacity and social capital. (Core)

IV.B.2.b)(1)(b) Conduct analyses of mental health needs to identify populations at risk of mental health problems, to recommend evidence-based prevention, screening, and early detection activities. (Core)

IV.B.2.b)(1)(c) Critically reflect on social determinants of mental illness, epidemiological studies on burden of disease, and evidence studies on mental health interventions, to determine and implement mental health illness prevention strategies at a primary, secondary, and tertiary level. (Core)

IV.B.2.b)(1)(d) Based on the need's assessment plans, develop, and implement need-based programs to promote mental health and wellbeing. These plans can encompass the psychoeducation of individuals or groups or more direct-action plans, in close cooperation with other stakeholders. (Core)

IV.B.2.b)(1)(e) Develop and use follow-up systems and multidisciplinary assessments to ensure that populations receive appropriate access to mental health services. (Core)

IV.B.2.b)(1)(f) Advise decision makers at local, provincial, national, and international levels on policies affecting mental health. (Core)

IV.B.2.b)(2) Clinical competencies in assessment of mental

health care users (MHCUs)

IV.B.2.b)(2)(a) Establish specialized theory-based therapeutic relationships with MHCU, their family and the community, and maintain personal and professional integrity in a therapeutic, person-centered relationship to promote goal-directed change. (Core)

IV.B.2.b)(2)(b) Using a culturally sensitive approach recognize the signs and symptoms of the mental disorders, identify problems and maladaptive behavior patterns, demonstrate in-depth knowledge of the causes and recognize and promptly and effectively intervene against the potential risk for self and others. (Core)

IV.B.2.b)(2)(c) Consider the unique age-specific aspects and specialist theory-based assessment techniques, to inform planning, implementation and evaluation across all levels of mental health care for the vulnerable mental health population throughout the lifespan. (Core)

IV.B.2.b)(2)(d) Collaborate with the MHCUs, their family, the community and multidisciplinary team (to collect collateral information) to conduct evidence based, comprehensive mental health assessments, using diagnostic tools and acceptable diagnostic criteria, and ordering diagnostic tests and procedures in line with scope of practice, to diagnose, prioritize, stabilize or refer – as appropriate – and develop collaborative diagnosis, care and treatment plans and rehabilitation. (Core)

IV.B.2.b)(2)(e) Collect, analyze data and interpret relative to physical, psychological, cultural, spiritual and social aspects of the MHCUs, family and/or community health and, using the data, derive nursing diagnoses and differential diagnoses to collaborate with the MHCU, family and/or community to formulate a care plan specific to the individual/family/community. (Core)

IV.B.2.b)(2)(f) Conduct assessment of crisis

situations (psychiatric emergencies) such as suicide or self-harm attempts, in instances of comorbidity and trauma, and determine appropriate care plans and interventions to enhance mental health. (Core)

IV.B.2.b)(2)(g) Record and report the findings of mental health assessments and interventions (paper-based and electronic) to relevant stakeholders accurately, completely and in a timely manner, in compliance with Nursing Practice standards and institutional policies. (Core)

IV.B.2.b)(3) Clinical competencies: planning of care, treatment and rehabilitation of MHCUs

IV.B.2.b)(3)(a) Formulate an individualized and person-centered, comprehensive care plan with identified care outcomes, based on nursing and differential diagnoses, findings from a comprehensive mental health assessment, inputs from other health team members and nursing practice standards. (Core)

IV.B.2.b)(3)(b) Apply critical thinking and clinical reasoning skills, underpinned by sound clinical judgement and in- depth knowledge of the etiology of mental illness, mental health care practices and psychopharmacology, to initiate appropriate management to: (Core)

- Develop effective care plans in collaboration with MHCUs and their families and the communities, to adhere to a recovery approach for individuals, families, and groups in institutions as well as the community.
- Develop therapeutic programs at local, national, and international levels.
- Involve communities and role-players in the planning and implementation of activities.

IV.B.2.b)(3)(c) Consult stakeholders (inclusive of MHCU, family, community, and advocacy groups) on policies and the development of infrastructure pertaining to mental health care delivery. (Core)

IV.B.2.b)(3)(d) Assess, review and revise planned activities regularly, in collaboration with MHCU, the family/community and other members of the health care team. (Core)

IV.B.2.b)(4) Clinical competencies in the implementation of care, treatment and rehabilitation of MHCUs

IV.B.2.b)(4)(a) Utilize knowledge of therapies and apply related clinical skills in working with the mental health care user, family and/or community to conduct a range of advanced evidence-based psychotherapeutic therapies and therapeutic programs, in accordance with the developed care plan and best practice standards for individuals, families, groups and communities, including psychosocial rehabilitation, using a recovery-based approach. Therapies will be based on the latest evidence such as psychoeducation, cognitive behavioral therapy (CBT), psychological first aid (PFA) or crisis therapy, structured family therapy etc. (Core)

IV.B.2.b)(4)(b) Exercise an advocacy role in care of MHCU, treatment and rehabilitation applying a recovery-supportive approach. (Core)

IV.B.2.b)(4)(c) Collaborate and take leadership in multidisciplinary teams and provide coordination and seamless continuation of care for MHCUs and provide the necessary support to the multidisciplinary team members according to the identified gaps in the implemented actions. (Core)

IV.B.2.b)(4)(d) Act as a consultant at clinical, organizational, national, and international levels. (Core)

IV.B.2.b)(4)(e) Maintain currency in knowledge of pharmacology (with an emphasis on psychopharmacology), the positive and negative effects of drugs on a person, and the administration of drugs; and administer medication and assess the effects of medication. (Core)

IV.B.2.b)(4)(f) Utilize psychosocial rehabilitation in a goal-directed manner to foster recovery and physical and mental well-being of the MHCU and enhance mental nurse/client relationships. (Core)

IV.B.2.b)(4)(g) Demonstrate the ability to conduct an interview, monitor mental health status; and collaboratively and continuously analyze, record and report interventions and MHCU responses to interventions and progress, as directed by care appropriate, evidence-based management tools. (Core)

IV.B.2.b)(4)(h) Provide support for MHCUs and families while in care, treatment, and rehabilitation to identify and assist MHCUs and families in overcoming barriers to successful recovery (e.g. adherence, stigma, finances, accessibility, and access to social support). (Core)

IV.B.2.b)(4)(i) Create and maintain a therapeutic environment during all levels of care. (Core)

IV.B.2.b)(4)(j) Develop and maintain current, accurate recordkeeping systems to manage effective communication throughout the health care system. (Core)

IV.B.2.b)(4)(k) Refer to other members of the multidisciplinary team where appropriate. (Core)

IV.B.2.b)(5) Essential clinical skills in the monitoring of care, treatment and rehabilitation of MHCUs

IV.B.2.b)(5)(a) Monitor, record and report progress towards expected outcomes accurately and completely and evaluate progress towards planned outcomes in consultation with health care users, families and/or caregiver and the health care team. (Core)

IV.B.2.b)(5)(b) Reflect on and review all implemented actions, to address any shortcomings or lack of progress, and review MHCU outcomes on a regular basis. (Core)

IV.B.2.b)(5)(c) Utilize evaluation data and electronic record data to monitor patient improvement and recovery. (Core)

IV.B.2.b)(5)(d) Demonstrate the ability to access and utilize technology to improve treatment and care of MHCU. (Core)

IV.B.2.b)(6) Clinical practice and management in a major incident, combat or disaster situation.

IV.B.2.b)(6)(a) Systematic assessment of the impact of a major incident or disaster in identifying needs, planning interventions, and providing and managing care in a resource-limited environment, while maintaining core competencies. (Core)

IV.B.2.b)(6)(b) Care for vulnerable people and their families/ significant others in a hostile, often unsafe, unstable environment, using appropriate competencies. Treat people with special needs and maintain ethical judgement towards casualties, hostile population groups or victims of hostile actions. (Core)

IV.B.2.b)(6)(c) Provide psychological first aid in times of trauma and crisis. (Core)

IV.B.2.b)(6)(d) Display professional development competencies, including monitoring, mentoring and evaluation, with a focus on competency in leadership, teamwork, and coordination in the hostile environment setting, while maintaining accountability and legal and ethical aspects. (Core)

IV.B.2.b)(7) Therapeutic communication and relationships

IV.B.2.b) (7)(a) Establish and maintain rapport with the MHCU and families/ significant others through therapeutic communication. (Core)

IV.B.2.b)(7)(b) Effectively apply the principles of facilitative and therapeutic interpersonal skills during interaction with MHCUs, their families, groups and communities, conveying respect for

diverse opinions. (Core)

IV.B.2.b)(7)(c) Effectively establish the principles of written, verbal and non-verbal communications skills within the mental health setting. (Core)

IV.B.2.b)(7)(d) Act as role model for and encourage person-centered communication, including MHCUs with compromised communication ability. (Core)

IV.B.2.b)(7)(e) Advocate for the MHCU and family in relation to all interventions and orders. (Core)

IV.B.2.b)(7)(f) Communicate with the family of the MHCU to orientate them about the mental health care interventions, technology and changing status. (Core)

IV.B.2.b)(7)(g) Demonstrate therapeutic use of self-principles to manage complex interpersonal situations. (Core)

Personal and Quality of Care

IV.B.2.c)(1) Quality improvement

IV.B.2.c)(1)(a) Always adopt safe practice.

Regularly analyze the mental health care system and its philosophy to align mental health nursing, accordingly, e.g. aligning with the Primary Health Care Approach and the Mental Health Care Act No. 17 (2002). (Core)

IV.B.2.c)(1)(b) Collaboratively develop and analyze indicators, checklists, and outcomes to monitor risks and unintended outcomes, the implementation of quality initiatives and effectiveness of mental health nursing practice, based on contextual variables such as admissions, length of stay, morbidity, mortality, and adverse events. (Core)

IV.B.2.c)(1)(c) Recognize workplace violence and aggression and implement risk mitigation strategies for the recognition and management of disruptive and violent behavior in the mental health care setting. (Core)

IV.B.2.c)(1)(d) Design innovations to effect change in mental health nursing practice and improve patient outcomes through the integration of evidence-based knowledge, skills, and attitude. (Core)

IV.B.2.c)(1)(e) Evaluate the practice environment and quality of mental health nursing rendered, in relation to existing evidence, feedback from MHCU and pre-set indicators, and implement appropriate strategies. (Core)

IV.B.2.c)(1)(f) Use the results of quality improvement activities to initiate changes in mental nursing practice and in the mental health care delivery systems. (Core)

IV.B.2.c)(2) Continuing Education

IV.B.2.c)(2)(a) Create and utilize learning opportunities for orientation and teaching of staff, MHCUs and families in the highly unfamiliar and stressful mental health care environment. (Core)

IV.B.2.c)(2)(b) Continuously explore and reflect on the self and staff competence and keep themselves and staff up to date with current health issues and health care trends in the dynamic environment of mental health nursing. (Core)

IV.B.2.c)(2)(c) Maintain personal growth through active participation in enriching sessions, to acquire clinical and professional knowledge, skills and attitudes/values. (Core)

IV.B.2.c)(2)(d) Apply the principles of teaching, learning and evaluation to design educational programs that enhance the knowledge and practice of staff. (Core)

IV.B.2.c)(2)(e) As a competent and responsible member of staff, participate in the facilitation of formal and informal education of students and staff. (Core)

IV.B.2.c)(2)(f) Provides frequent positive and

constructive feedback in a way that motivates both under-performing and high-performing individuals. (Core)

IV.B.2.c)(2)(g) Act as a competent and accountable consultant or resource person for mental health care in the health care facility to enable staff to develop to their full potential. (Core)

IV.B.2.c)(2)(h) Maintain complete and accurate clinical records (written and electronically) that provide up to date evidence of competency and lifelong learning. (Core)

IV.B.2.c)(2)(i) Participate actively in formative and summative assessment of students, using evidence-based assessment tool. (Core)

Management and Leadership

IV.B.2.d)(1) Demonstrate professional accountability and advocacy in executing clinical, managerial and educational activities to empower staff members and promote quality care (Core)

IV.B.2.d)(2) Share, foster and translate the vision and mission of the organization into the practice of nursing in the mental health care setting. (Core)

IV.B.2.d)(3) Coordinate the care, treatment and rehabilitation of MHCUs across the healthcare journey, to achieve optimal outcomes within this environment. (Core)

IV.B.2.d)(4) Oversee the care, treatment and rehabilitation given by staff members and multidisciplinary team members, while ensuring accountability for the quality of care given to MHCUs and their families. (Core)

IV.B.2.d)(5) Develop and implement a succession plan to ensure continuity of care (and mental health nursing leadership) in the mental health nursing practice. (Core)

IV.B.2.d)(6) Liaise effectively between various parties in effort to uphold the image of the profession and empower colleagues. (Core)

IV.B.2.d)(7) Influence decision-making bodies to improve

the mental health nursing practice environment and patient outcomes. (Core)

IV.B.2.d)(8) Participate in efforts to influence health care policy on behalf of MHCUs and the profession. (Core)

IV.B.2.d)(9) Participate in designing systems that support effective teamwork and positive outcomes in the mental health care environment. (Core)

IV.B.2.d)(10) Manage and evaluate innovation and embrace high leadership opportunities to facilitate change in the mental health care setting through encouraging creativity, problem solving and critical thinking skills in staff. (Core)

Research

IV.B.2.e)(1) Engage in research activities to inform evidence-based practice, to improve and promote optimal patient outcomes. (Core)

IV.B.2.e)(2) Display basic knowledge of research methods and of application of scientific research. (Core)

IV.B.2.e)(3) Critically analyze and discuss the findings of research in the field of mental health care within the healthcare team and negotiate for the implementation of relevant and appropriate applicable findings in the mental health setting. (Core)

IV.B.2.e)(4) Provide and translate evidence-based recommendations for MHCU interventions. (Core)

IV.B.2.e)(5) Participate in the evaluation of mental health series and interventions. (Core)

IV.B.2.e)(6) Disseminate research findings through activities such as presentations, publications, consultations and journal clubs to a variety of audiences that include but are not limited to healthcare providers in the mental health care setting. (Core)

IV.C Curriculum Organization and Resident Experiences

IV.A.13. The curriculum must be structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity. (Core)

IV.A.13.a) Assignment of rotations must be structured with sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, relationships with faculty members, and high-quality assessment and feedback. (Core)

IV.A.13.b) Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team. (Core)

IV.D Scholarship

Scholarly activities must include discovery, integration, application, and teaching.

IV.A.14. Program Responsibilities

IV.A.14.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

IV.A.14.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)

IV.A.14.c) The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)

IV.A.15. Faculty Scholarly Activity

IV.A.15.a) Among their scholarly activities, programs must demonstrate accomplishments in at least one of the following domains: (Core)

- Research in education, patient care, or population health
- Case-presentation publications
- Quality improvement and/or patient safety initiatives
- Systematic reviews, review articles or case reports
- Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
- Contribution to professional committees, educational organizations, or editorial boards
- Innovations in education

IV.A.16. Resident Scholarly Activity

IV.A.16.a) While in the program, residents must engage in at

least one of the following scholarly activities: participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or service on professional committees. (Core)

IV.A.16.b) Residents must participate in scholarly projects. (Core)

IV.D.3.b)(1) Residents must complete a scholarly project relevant to the specialty which was conducted under supervision of a faculty member. (Core)

IV.D.3.b)(2) The project shall be presented in a local, national or international specialty conference. (Core)

IV.D.3.b)(3) The proof of presentation in a nursing/medical conference, will be part of the resident's portfolio and will be documented in the final summative evaluation prior to Board Certification, in accordance with NIHS guidelines. (Core)

V. Evaluation

V.A Resident Evaluation

Formative and summative evaluation have distinct definitions.

Formative evaluation is monitoring resident learning and providing ongoing feedback that can be used by residents to improve their learning.

More specifically, formative evaluations help:

- residents identify their strengths and weaknesses and target areas that need work.
- program directors and faculty members recognize where residents are struggling and address problems immediately.

Summative evaluation is evaluating a resident's learning by comparing the residents against the goals and objectives of the rotation and program, respectively and is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.

A planned, defined and implemented system of resident assessment must be in place with clearly defined methods and identified level of the expected outcomes. (Core)

IV.A.17. Formative evaluation

There must be a system of formative documented evaluation of resident's performance at the completion of the rotation and assignments. (Core)

IV.A.17.a) The formative evaluator must:

V.A.1.a)(1) Assess residents' performance based on the seven professional practice standards namely person-centered care, ethical and legal practice, communication and collaboration, research and evidence-based practice, community and public health, leadership and management, and informatics and technology. (Core)

V.A.1.a)(2) Include a review of case volume to ascertain comprehensive coverage. (Core)

V.A.1.a)(3) Use formal in-service cognitive exams to monitor knowledge when appropriate. (Core)

V.A.1.a)(4) Use multiplicity in resident evaluation (e.g. faculty, self, peer evaluation. online and simulation). (Core)

V.A.1.a)(5) Document progressive resident performance improvement. (Core)

V.A.1.a)(6) Provide residents with a documented semi-annual evaluation on performance with feedback to guide their learning plans. (Core)

IV.A.18. Summative evaluation

There must be a system of documented summative evaluation of resident performance at the end of the rotation/year/program to verify that the resident demonstrated sufficient competence to enter practice without supervision. (Core)

IV.A.18.a) Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)

V.A.2.a)(1) More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation. (Core)

IV.A.18.b) Evaluation must be documented at the completion of the assignment. (Core)

IV.A.18.c) The program must provide an objective performance evaluation based on the Competencies, and must: (Core)

V.A.2.c)(1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members) (Core)

V.A.2.c)(2) provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)

IV.A.18.d) The program director or their designee, with input from the Clinical Competency Committee, must:

V.A.2.d)(1) meet with and review with each resident their documented semi-annual evaluation of performance, including progress. (Core)

V.A.2.d)(1)(a) Review of resident Case-Logs must be a part of the semi-annual review. (Detail)

V.A.2.d)(2) assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; (Core)

V.A.2.d)(3) develop plans for residents failing to progress, following both the NIHS Emirati Board and institutional policies and procedures. (Core)

Residents who are experiencing difficulties with achieving progress may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the NIHS recognizes that there are situations which require more significant intervention that

may alter the time course of resident progression. To ensure due process, it is essential that the program director follow NIHS and institutional policies and procedures.

V.A.2.d)(4) The evaluations of a resident's performance must be accessible for review by the resident. (Core)

IV.A.19. Final Evaluation

IV.A.19.a) The program director must provide a final evaluation for each resident upon completion of the program. The resident must pass the clinical and written assessment which will include but not limited to OSCE-scenario based skill assessment, preceptors/ mentors' evaluation- overall performance, exam covering core mental health topics. (Core)

V.A.3.a)(1) The specialty-specific Competencies, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core)

V.A.3.a)(2) The final evaluation must:

V.A.3.a)(2)(a) become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Core)

V.A.3.a)(2)(b) verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; (Core)

V.A.3.a)(2)(c) consider recommendations from the Clinical Competency Committee; (Core)

V.A.3.a)(2)(d) be shared with the resident upon completion of the program. (Core)

IV.A.20. A Clinical Competency Committee must be appointed by the program director. (Core)

IV.A.20.a) The Clinical Competency Committee must include at least three members of the program faculty, at least one of whom is a core faculty member. (Core)

V.A.4.a)(1) Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)

V.A.4.a)(2) The Program Director has final responsibility for resident evaluation and promotion decisions. (Core)

IV.A.20.b) The Clinical Competency Committee must:

V.A.4.b)(1) review all residents evaluation at least semi-annually; (Core)

V.A.4.b)(2) determine each resident's progress on achievement of the specialty-specific Competencies; (Core)

V.A.4.b)(3) meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress, promotion, remediation, or dismissal; (Core)

V.A.4.b)(4) meet at least quarterly, keep minutes of their meetings and report to the Program Director. (Core)

V.B Faculty Evaluation

IV.A.21. The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

IV.A.21.a) This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, review of patient outcomes, professionalism, research, and scholarly activities. (Core)

IV.A.21.b) This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)

IV.A.22. Faculty members must receive feedback on their evaluations at least annually. (Core)

IV.A.23. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)

IV.A.24. The program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. Therefore, the annual review of the program's faculty members is mandatory and can be used as input into the Annual Program Evaluation. (Core)

V.C Program Evaluation and Improvement

IV.A.25. The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)

The performance of residents and faculty members reflects program quality and will use metrics to reflect the program's goals.

The Program Evaluation Committee must present the Annual Program Evaluation Report in written form to be discussed with all program faculty and residents as a part of continuous improvement plans.

IV.A.25.a) The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least two or more residents from different years. (Core)

IV.A.25.b) Program Evaluation Committee responsibilities must include:

V.C.1.b)(1) acting as an advisor to the program director, through program oversight; (Core)

V.C.1.b)(2) review of the program's requirements, both NIHS Emirati Board required and program self-determined goals, and the progress toward meeting them; (Core)

V.C.1.b)(3) guiding ongoing program improvement, including developing new goals based upon outcomes; (Core)

V.C.1.b)(4) review of the current operating environment to identify strengths, challenges, opportunities, and threats related to the program's mission and aims. (Core)

IV.A.25.c) The Program Evaluation Committee should consider the following elements in its assessment of the program:

V.C.1.c)(1) program curriculum; (Core)

V.C.1.c)(2) outcomes from prior Annual Program Evaluation(s); (Core)

V.C.1.c)(3) NIHS letters of notification including citations, areas for improvement, and comments; (Core)

V.C.1.c)(4) the quality and safety of patient care; (Core)

V.C.1.c)(5) Aggregate residents and the faculty:

V.C.1.c)(5)(a) engagement in quality improvement and patient safety; (Core)

V.C.1.c)(5)(b) scholarly activity; (Core)

V.C.1.c)(5)(c) resident and faculty surveys; (Core)

V.C.1.c)(5)(d) written evaluations of the program.(Core)

V.C.1.c)(6) Aggregate resident:

V.C.1.c)(6)(a) board pass and certification rates; (Core)

V.C.1.c)(6)(b) graduates' performance. (Core)

V.C.1.c)(7) Aggregate faculty:

V.C.1.c)(7)(a) faculty evaluation; (Core)

V.C.1.c)(7)(b) professional development. (Core)

IV.A.25.d) The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)

IV.A.25.e) The Annual Program Evaluation review, including the action plan, must:

V.C.1.e)(1) be distributed to and discussed with the members of the teaching faculty and the residents; (Core)

V.C.1.e)(2) be submitted to the DIO. (Core)

IV.A.25.f) A process must be in place to incorporate stakeholder perspectives and feedback, ensuring that

confidentiality is maintained. (Core)

IV.A.26. The program will be accredited and reaccredited by the NIHS in accordance with the NIHS Accreditation Bylaws. (Core)

IV.A.26.a) The program must complete a Self-Study before its reaccreditation Site Visit. (Core)

IV.A.26.b) Self-Study is an objective, comprehensive evaluation of the residency program with the aim of improving it. (Core)

IV.A.27. The goal of NIHS-accredited education is to train nurses who seek and achieve a board certification. One measure of the effectiveness of the educational program is the ultimate pass rate. (Core)

IV.A.28. Under the guidance of the Program Director all eligible program graduates should take the certifying examination conducted by the NIHS Emirati Board to obtain the Board Certification. (Core)

VI. The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- Excellence in safety and quality of care.
- Excellence in professionalism through faculty modeling of:
  - the effacement of self-interest in a humanistic environment;
  - the joy of curiosity, problem-solving, intellectual rigor, and discovery.
- Commitment to the well-being of the students, residents, faculty members, and all members of the health care team.

VI.A Patient Safety, Quality Improvement, Supervision and Accountability

i.Patient Safety and Quality Improvement

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

1. Patient Safety

VI.A.1.a)(1) Culture of Safety

VI.A.1.a)(1)(a) The program, its faculty and residents,

must actively participate in patient safety systems and contribute to a culture of safety. (Core)

VI.A.1.a)(1)(b) The program must have a structure that promotes safe, inter-professional, team-based care (Core)

VI.A.1.a)(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

VI.A.1.a)(3) Patient Safety Events

VI.A.1.a)(3)(a) Residents, faculty members, and other clinical staff members must:

- Know their responsibilities in reporting patient safety events at the clinical site; (Core)
- know how to report patient safety events, including near misses, at the clinical site; (Core)
- be provided with summary information on their institution's patient safety reports. (Core)

VI.A.1.a)(3)(b) Residents must participate as team members in real and/or simulated inter-professional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

VI.A.1.a)(4) Resident Education and Experience in Disclosure of Adverse Events

VI.A.1.a)(4)(a) All residents must receive training in how to disclose adverse events to patients and families. (Core)

VI.A.1.a)(4)(b) Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)

2. Quality Improvement

VI.A.1.b)(1) Education in Quality Improvement

VI.A.1.b)(1)(a) A system must be in place for internal quality improvements. (Core)

VI.A.1.b)(1)(b) Documentation and reporting systems must be in place, including the production of guidelines, manuals, and reports. (Core)

VI.A.1.b)(1)(c) Residents and faculty must be involved in quality improvement processes as part of interprofessional teams. The results must be used to improve the program. (Core)

ii.Supervision and Accountability

1. Supervision in the setting of nursing education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice and establishes a foundation for continued professional growth. (Core)

2. Supervision may be exercised through a variety of methods. The care provided by the residents must be adequately supervised by the appropriate availability of the supervising faculty member. (Core)

VI.A.2.b)(1) The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

VI.A.2.b)(2) The program must define when the physical presence of a supervising nurse is required. (Core)

3. Levels of Supervision

To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.A.2.c)(1) Direct Supervision: the supervisor is physically present with the resident during the key portions of the patient interaction. (Core)

VI.A.2.c)(1)(a) The program must have clear

guidelines that delineate which competencies must be demonstrated to determine when a resident can progress to indirect supervision. (Core)

VI.A.2.c)(1)(b) The program director must ensure that clear expectations exist and are communicated to the residents, and that these expectations outline specific situations in which a resident would still require direct supervision. (Core)

VI.A.2.c)(2) Indirect Supervision: the supervisor is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision. (Core)

VI.A.2.c)(3) Oversight: the supervisor is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

4. The privilege of progressive authority, responsibility, and conditional independence role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)

VI.A.2.d)(1) The program director must evaluate each resident's abilities. (Core)

VI.A.2.d)(2) Faculty members must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)

5. Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)

VI.A.2.e)(1) Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)

6. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)

VI.B Fatigue Mitigation

iii. Programs must:

1. educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; (Core)

2. educate all faculty members and residents in alertness management and fatigue mitigation processes; (Core)

3. encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

iv. Each program must ensure continuity of patient care, consistent with the program's policies and procedures, if a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

VI.C Clinical Responsibilities, Teamwork, and Transitions of Care

v. Clinical Responsibilities

The clinical responsibilities for each resident must be based on educational level, patient safety, resident ability, severity, and complexity of patient illness/condition. (Core)

vi. Teamwork

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate for the delivery of care in the specialty and larger health system. (Core)

vii. Transitions of Care

1. Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

2. Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand- over processes to facilitate both continuity of care and patient safety. (Core)

3. Programs must ensure that residents are competent in

communicating with team members in the hand-over process. (Outcome)

4. Each program must ensure continuity of patient care, consistent with the program's policies and procedures, if a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core)

VI.D Clinical Experience and Education

viii. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 48 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities and clinical work. (Core)

ix. Mandatory Time Free of Clinical Work and Education

1. The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

2. Residents should have eight hours off between scheduled clinical work and education periods. (Detail)

VI.D.2.b)(1) There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 48-hour and the one-day-off-in-seven requirements. (Core)

3. Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). (Core)

x. Maximum Clinical Work and Education Period Length

1. Clinical and educational work periods for residents must not exceed 12 hours of continuous scheduled clinical assignments. (Core)

VI.D.3.a)(1) Up to four hours of additional time may be used

for activities related to patient safety, such as providing effective transitions of care, and/or resident education. (Core)

VI.D.3.a)(1)(a) Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

xi. Moonlight

Residents are not permitted to moonlight. (Core)

*Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical/nursing educational program.

†Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

‡Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical/nursing education.

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