NATIONAL INSTITUTE FOR HEALTH SPECIALITIES

NIHS Program Requirements for Specialty Training in Pediatric Nursing

The Emirati Board in Pediatric Nursing Residency 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 care through expanded knowledge and clinical expertise of registered pediatric nurses.

The program's objectives are to develop and strengthen:

- Knowledge, desirable attitude and application of skill in systematic and comprehensive assessment, care provision and record keeping for pediatric patients as autonomous and responsible practitioners
- Critical thinking skills using health systems approach problem-solve and make complex decisions in pediatric care contexts.
- Lead in the design, implementation, and evaluation of quality improvement processes in pediatric care.
- Leadership of registered nurses as best practice and management role models in the delivery of pediatric care.
- Influencing the delivery of pediatric nursing through engagement in policy development at an institutional, national, or international level.

Int. C. Definition of Specialty

Pediatric nursing science is a specialty in nursing that partners with parents to provide for the healthcare of children. This program prepares nurses with specialist qualifications to address the preventative, promotive and curative healthcare needs of children.

Int. D. Length of educational program

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

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 pediatric nursing 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)

I.B. Participating Sites

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

I.B.1. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)

I.B.2. 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.B.2.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.B.3. The program must monitor the clinical learning and working environment at all participating sites. (Core)

I.B.3.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.B.4. Resident assignments away from the Sponsoring Institution should not prevent residents' regular participation in required didactics. (Core)

I.C. Resources

I.C.1. 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.C.2. 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.C.2.a) access to food while on duty; (Core)

I.C.2.b) security and safety measures appropriate to the participating site. (Core)

I.C.3. Residents must have ready access to pediatric care 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.C.4. The program's educational and clinical resources must be adequate to support the number of residents appointed to the program. (Core)

I.C.4.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.C.4.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.C.5. The program must provide a positive learning environment in a flexible, compassionate culture promoting teamwork and interdisciplinary and interprofessional learning environment. (Core)

I.C.6. Any other resource requirement considered necessarily for education. (Core)

I.D. Other Learners and Other Care Providers

The presence of other learners and other care providers, including, but not limited to, residents from other programs such as medical, nursing or other. (Core)

I.D.1. 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)

I.D.2. Additionally, the program must ensure an adequate number of nurses are available in GMEC to support the residents' education and clinical training, minimizing disruptions and maintaining the quality of the learning environment. (Core)

II. Personnel

II.A. Program Director

II.A.1. There must be one faculty member appointed as program director for the pediatric nursing 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 pediatric nurse specialist, or hold at least a graduate qualification in pediatric nursing and clinical experience in pediatric nursing. (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 associate program director must be licensed as a pediatric nurse specialist, or hold at least a graduate qualification in pediatric nursing and clinical experience in pediatric nursing. (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.B.1. 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.b) The ratio of all faculty to residents must be a minimum of 1:1. (Core).

II.B.2. Faculty members must:

II.B.2.a) be role models of professionalism; (Core)

II.B.2.b) demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care; (Core)

II.B.2.c) demonstrate a strong interest in the education of residents; (Core)

II.B.2.d) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)

II.B.2.e) administer and maintain an educational environment conducive to educating residents; (Core)

II.B.2.f) regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Core)

II.B.2.g) At least one member of the faculty should support resident scholarly activities. (Core)

II.B.3. Faculty Qualifications

II.B.3.a) Faculty must be pediatric nurse specialists that are licensed to practice and hold appropriate institutional appointments. (Core)

II.B.3.b) The faculty may include qualified pediatricians. (Core)

II.B.3.c) Administrative staff must have qualifications and experience suitable for their roles. (Core)

II.B.4. 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.B.4.a) Core faculty members must be designated by the program director. (Core)

II.B.4.b) Core faculty members must complete the annual NIHS Faculty Survey. (Core)

II.C. Program Coordinator

II.C.1. There must be a program coordinator. (Core)

II.C.2. 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) hold a Bachelor of Science in Nursing (BSN) and have successfully completed the Transition to Practice (TTP) Program (applicable to newly graduated nurses and preferably in pediatric setting); (Core)

OR

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.B.1. The program director must not appoint more residents than approved by the Central Accreditation Committee. (Core)

III.B.2. All changes in resident complement must be approved by the NIHS Central Accreditation Committee. (Core)

III.B.3. The number of residents appointed to the program must not exceed the program's educational and clinical resources. (Core)

III.B.4. There must be a minimum of 4 residents registered in each year. (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 pediatric acute emergency and acute in- patient care, chronic care, community, primary healthcare services, and counseling services for 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 program must ensure an appropriate balance between educational and service components within the residency program. (Core)

IV.A.7.a) At least 70% of the total residency duration must be dedicated to skills development and clinical education. (Core)

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

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

IV.A.9.a) 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 Pediatric care Nurse Specialist

IV.B.1. Entry-to-practice competencies for nurse specialist

IV.B.1.a) Client Care

IV.B.1.a)(1) Comprehensive pediatric care

- Provides holistic, evidence-based nursing care tailored to the unique physical, emotional, and psychosocial needs of pediatric patients across various developmental stages. (Core)
- Maintains a child- and family-centered approach to foster optimal health outcomes, safety, and comfort. (Core)
- Shares information at all times to foster participation in decision-making with the child or youth and their family. (Core)

IV.B.1.a)(2) Family-centered care:

- Demonstrates cultural sensitivity and respect for the diversity of children and their families; offers implementation and inclusion of language specialists (interpreters/translators) where applicable. (Core)
- Assesses health literacy of all caregivers and patients depending on age and developmental stage; implements health literacy literature, graphics, and media correlated to comprehension and function. (Core)
- Demonstrates ability to construct care conferences with family and staff to address decisional conflict and provide access to resources. (Core)
- Directs care planning and selection of educational strategies depending on age appropriateness and developmental stage. (Core)
- Demonstrates strategies to empower patients and families in all aspects of the healthcare process. (Core)

IV.B.1.a)(3). Safe environment

- Implements child-specific safety protocols, including accurate medication dosing, infection control, and injury prevention measures. (Core)
- Ensures a child-friendly, developmentally appropriate environment that minimizes stress and promotes healing. (Core)

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

IV.B.1.a)(3)(a) Thorough and age-specific assessments

- Conducts comprehensive physical, developmental, and psychosocial assessments. (Core)
- Assesses growth, development, and behavioral health across the pediatric lifespan. (Core)
- Utilizes diagnostic tools and evaluates developmental milestones to identify deviations from norms. (Core)
- Screens for abuse, neglect, and exposure to violence. (Core)
- Shares findings with the family and healthcare team, referring when necessary. (Core)

IV.B.1.a)(3)(b) Critical thinking and reflective practice

- Integrates critical thinking to interpret findings and prioritize care needs. (Core)
- Applies reflective practice to refine assessment techniques. (Core)
- Uses clinical reasoning and critical enquiry to guide diagnostic decisions. (Core)

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

- Formulates nursing diagnoses based on comprehensive, evidence informed assessments. (Core)
- Identifies health issues, risks, and strengths in collaboration with the child and family. (Core)

IV.B.1.a)(3)(d) Clinical judgment

- Differentiates between normal and pathological findings. (Core)
- Uses diagnostic reasoning for timely and effective interventions. (Core)
- Synthesizes assessment data to create individualized, family-centered care plans with SMART goals. (Core)
- Prioritizes safe and effective action plans within available resources. (Core)
- Collaborates with families and care teams using health literacy principles. (Core)

- Shares clear, accurate, timely information to enable ethical decision-making. (Core)

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

IV.B.1.a)(4)(a) Individualized care plans

- Develops and implements personalized care strategies addressing physical, developmental, and psychosocial needs. (Core)
- Integrates multidisciplinary input in complex cases. (Core)

IV.B.1.a)(4)(b) Emergency and critical care management

Specialty background: *Residents must develop competence in the recognition and initial management of pediatric emergencies that are commonly encountered in general pediatric practice.*

The targeted emergencies include respiratory conditions such as bronchiolitis, asthma exacerbation, croup, and upper airway obstruction; cardiovascular emergencies including hypovolemic shock, septic shock, congenital heart disease decompensation, and arrhythmias; neurological emergencies such as status epilepticus, febrile seizures, and altered mental status; infectious emergencies including sepsis, meningitis, and severe dehydration with electrolyte imbalance; trauma-related emergencies requiring stabilization of head injuries, burns, and fractures; toxicological emergencies related to accidental ingestion or poisoning; and endocrine or metabolic crises such as diabetic ketoacidosis and adrenal insufficiency.

The emphasis remains on managing emergencies within the scope of general pediatric care, without extending into specialized emergency procedures.

- Delivers prompt interventions in emergencies, using advanced monitoring techniques. (Core)
- Encourages family presence and involvement during acute care. (Core)

IV.B.1.a)(5) Collaboration, consultation, and referral

IV.B.1.a)(5)(a) Interprofessional collaboration

- Works with physicians and allied health to ensure holistic care. (Core)

- Participates in rounds, handoffs, and team discussions for care continuity. (Core)

IV.B.1.a)(5)(b) Effective referrals

- Identifies need for specialized care and facilitates referrals. (Core)
- Involves families in referral discussions to support decision-making. (Core)

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

IV.B.1.a)(6)(a) Child and family education

- Provides culturally appropriate education on health, prevention, and self-care. (Core)
- Encourages participation in health promotion. (Core)
- Supports nutrition, physical activity, and developmental well-being. (Core)
- Identifies and addresses feeding issues and behavioral concerns. (Core)

IV.B.1.a)(6)(b) Community engagement

- Participates in community initiatives addressing social determinants of health. (Core)
- Collaborates with schools and community groups to improve child health. (Core)

IV.B.1.b) Quality improvement and research

IV.B.1.b)(1) Continuous quality improvement

- Leads data-driven QI efforts to improve safety, service, and outcomes. (Core)
- Communicates QI results to foster a culture of excellence. (Core)

IV.B.1.b)(2) Research and evidence integration

- Demonstrates understanding of the research process. (Core)
- Appraises and integrates evidence into clinical practice. (Core)

- Participates in and disseminates research to improve care. (Core)

IV.B.1.c) Leadership

IV.B.1.c)(1) Role modeling and mentorship

- Guides junior staff and students; models professional behavior. (Core)
- Upholds legal and ethical nursing standards. (Core)

IV.B.1.c)(2) Team leadership

- Leads interprofessional teams with shared decision-making. (Core)
- Advocates for pediatric system improvements. (Core)

IV.B.1.d) Education

IV.B.1.d)(1) Educational outreach

- Develops culturally relevant education for families and communities. (Core)
- Promotes child health education in partnership with schools. (Core)

IV.B.2. Competencies for graduate nurse specialist

IV.B.2.a) Professional, ethical, and legal practice

IV.B.1.a)(1) Professional practice

- Demonstrates advanced pediatric expertise and evidence-based interventions. (Core)
- Leads initiatives that improve outcomes and institutional performance. (Core)
- Collaborates in teams and mentors others effectively. (Core)
- Advocates for pediatric safety and quality protocols. (Core)

IV.B.1.a)(2) Ethical practice

- Upholds autonomy, beneficence, non-maleficence, and justice. (Core)

- Promotes and protects child and family rights. (Core)
- Demonstrates cultural sensitivity and ethical leadership. (Core)
- Maintains professional boundaries and integrity. (Core)

IV.B.1.a)(3) Legal practice

- Complies with UAE healthcare laws and guidelines. (Core)
- Maintains accurate and legal documentation. (Core)
- Implements risk reduction strategies and obtains informed consent. (Core)
- Reports abuse and advocates for legal protections. (Core)

IV.B.2.b) Quality of practice

- Follows and implements evidence-based pediatric protocols. (Core)
- Reports observed care trends and issues to senior staff for analysis. (Core)
- Participates in initiatives to reduce errors and infections through safe practice. (Core)
- Supports family involvement in quality-related discussions and feedback. (Core)
- Utilizes electronic health records appropriately for documentation. (Core)
- Assists in basic audits and monitoring activities as directed. (Core)
- Understands and follows standardized procedures in daily nursing care. (Core)
- Complies with pediatric safety bundles such as hand hygiene and infection control. (Core)
- Participates in staff training sessions related to quality and safety. (Core)
- Observes and reports patient outcomes to assist in improvement measures. (Core)
- Participates in unit-level quality meetings or discussions when appropriate. (Core)

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.C. Curriculum Organization and Resident Experiences

IV.C.1. The curriculum must be structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity. (Core)

IV.C.1.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.C.1.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.C.2. Mandatory Rotations: (Core)

IV.C.2.a) General pediatric medical (Core)

IV.C.2.b) General pediatric surgical (Core)

IV.C.2.c) Pediatric emergency department (Core)

IV.C.2.d) Community/primary health care pediatrics (Core)

IV.C.2.e) Pediatric outpatient clinics (Core)

IV.C.3. Elective Rotations (Core)

Specialty background: *Elective rotations are designed to broaden residents' clinical experience and support their professional development within the scope of general pediatrics.*

These rotations provide opportunities to explore specialized areas of pediatric care, enhance clinical competencies, and align with individual learning goals and interests.

IV.C.3.a) Pediatric cardiology

IV.C.3.b) Pediatric neurology

IV.C.3.c) Pediatric endocrinology

IV.C.3.d) Pediatric nephrology

IV.C.3.e) Pediatric hematology and oncology

IV.C.3.f) Pediatric pulmonology

IV.C.3.g) Pediatric gastroenterology

IV.C.4. Core theoretical modules: (Core)

IV.C.4.a) Principles of pediatric nursing practice (Core)

IV.C.4.b) Comprehensive pediatric health assessment and developmental evaluation (Core)

IV.C.4.c) Family engagement and communication in pediatric care (Core)

IV.C.4.d) Safe pediatric medication management and pharmacological practices (Core)

IV.C.4.e) Essentials of pediatric critical and high-acuity care (Core)

IV.C.3.f) Leadership and professional identity in pediatric nursing (Core)

IV.C.3.g) Emergency preparedness and acute pediatric response (Core)

IV.C.3.h) Integrating research and evidence-based practice in pediatric settings (Core)

IV.D. Scholarship

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

IV.D.1. Program Responsibilities

IV.D.1.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

IV.D.1.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)

IV.D.1.c) The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)

IV.D.2. Faculty Scholarly Activity

IV.D.2.a) Among their scholarly activity, 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.D.3. Resident Scholarly Activity

IV.D.3.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.D.3.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)

V.A.1. Formative evaluation

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

V.A.1.a) The formative evaluator must:

V.A.1.a)(1) Assess residents' performance based on the 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)

V.A.2. 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)

V.A.2.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)

V.A.2.b) Evaluation must be documented at the completion of the assignment. (Core)

V.A.2.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)

V.A.2.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)

V.A.3. Final Evaluation

V.A.3.a) The program director must provide a final evaluation for each resident upon completion of the program. (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 behaviours 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)

V.A.4. A Clinical Competency Committee must be appointed by the program director. (Core)

V.A.4.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)

V.A.4.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

V.B.1. The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

V.B.1.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)

V.B.1.b) This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)

V.B.2. Faculty members must receive feedback on their evaluations at least annually. (Core)

V.B.3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)

V.B.4. 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

V.C.1. 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 a written form to be discussed with all program faculty and residents as a part of continuous improvement plans.

V.C.1.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)

V.C.1.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)

V.C.1.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)(d) engagement in quality improvement and patient safety; (Core)

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

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

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

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

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

V.C.1.c)(6)(d) 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)

V.C.1.d) The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)

V.C.1.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)

V.C.1.d) A process must be in place to incorporate stakeholder perspectives and feedback, ensuring that confidentiality is maintained.

V.C.2. The program will be accredited and reaccredited by the NIHS in accordance with NIHS Accreditation Bylaws. (Core)

V.C.2.a) The program must complete a Self-Study before its reaccreditation Site Visit. (Core)

V.C.2.b) The Self-Study is an objective, comprehensive evaluation of the residency program with the aim to improve it. (Core)

V.C.3. 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)

V.C.4. 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

VI.A.1. 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.

VI.A.1.a) 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 of 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)

VI.A.1.b) 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)

VI.A.2. Supervision and Accountability

VI.A.2.a) 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)

VI.A.2.b) Supervision may be exercised through a variety of methods. The care provided by the resident 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)

VI.A.2.c) 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)

VI.A.2.d) 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)

VI.A.2.e) 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)

VI.A.2.f) 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

VI.B.1. Programs must:

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

VI.B.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; (Core)

VI.B.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

VI.B.2. 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

VI.C.1. 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.C.2. 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 to the delivery of care in the specialty and larger health system. (Core)

VI.C.3. Transitions of Care

VI.C.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

VI.C.3.b) 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)

VI.C.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-over process. (Outcome)

VI.C.3.d) 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

VI.D.1. 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)

VI.D.2. Mandatory Time Free of Clinical Work and Education

VI.D.2.a) 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)

VI.D.2.b) 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. (Detail)

VI.D.2.c) 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)

VI.D.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for residents must not exceed 12 hours of continuous scheduled clinical assignments. (Core)

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

VI.F.5. 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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