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**National Institute for Health Specialties**

**Rubrics for Accreditation Requirements (Institutional)**

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| **GENERAL INFORMATION** | | | | | |
| **1 Institution Information** | | | | | |
| Entity name |  | | | | |
| City |  | | | | |
| Date |  | | | | |
| **Requirement** | **Status** | | | **Evidence** | **Comments** |
| **Met** | **P. Met** | **Not Met** |
| **DOMAIN 1: GOVERNANCE** | | | | | |
| **Component 1.1. Governance Structures** | | | | | |
| * + 1. The availability of a written statement of commitment of the Sponsoring Institution’s (SI) to provide the necessary educational, financial, and human resources to support GME. The statement must be signed by representatives of the SI’s governing body, administration, and GME leadership within a minimum of one year prior to an institutional site visit. |  |  |  |  |  |
| * + 1. The availability of an organized administrative system, led by a designated institutional official (DIO) in collaboration with a Graduate Medical Education Committee (GMEC), must oversee all programs in the SI. |  |  |  |  |  |
| * + 1. DIO appointed according to the requirements. |  |  |  |  |  |
| * + 1. GMEC constituted according to the requirements. |  |  |  |  |  |
| * + 1. GMEC voting membership include the DIO, residents and fellows nominated by their peers, representative program directors, and administrators. |  |  |  |  |  |
| * + 1. The GMEC meet at least quarterly and maintain written minutes. |  |  |  |  |  |
| * + 1. Procedures to ensure that DIO designee can perform the duties of the DIO in his/her absence. |  |  |  |  |  |
| * + 1. The availability of GMEC annual report to the SI leadership and governing body of major participating sites. The content of the annual report is as per the requirements. |  |  |  |  |  |
| **Component 1.2. Governance Relationships** | | | | | |
| * + 1. Communication mechanisms exist between the GMEC and all program directors within the institution. |  |  |  |  |  |
| * + 1. The presence of effective communication mechanisms between program directors and the site directors at each participating site to maintain proper oversight at all clinical sites. |  |  |  |  |  |
| * + 1. Integration of training with clinical governance e.g. committees membership. |  |  |  |  |  |
| * + 1. All programs has established program letters of agreement (PLA) with its participating sites. |  |  |  |  |  |
| * + 1. Effective communication with the NIHS. |  |  |  |  |  |
| **Component 1.3. Governance Processes** | | | | | |
| * + 1. Availability of policy/manual for residency training. |  |  |  |  |  |
| * + 1. Availability of financial plan and budgeting for residency. |  |  |  |  |  |
| * + 1. Quality assurance system and plan for residency. |  |  |  |  |  |
| **OVERALL ASSESSMENT OF DOMAIN 1:** |  | | | | |
| **Domain 2: Training environment** | | | | | |
| **Component 2.1. Physical setting and infrastructure** | | | | | |
| * + 1. Adequate clinical space, patient load, with good case mix. |  |  |  |  |  |
| * + 1. Adequate communication resources, technological support, information system e.g. databases. |  |  |  |  |  |
| * + 1. Adequate educational space. |  |  |  |  |  |
| * + 1. Adequate patient support services: peripheral intravenous access placement, phlebotomy, laboratory, and transporter services. |  |  |  |  |  |
| * + 1. Adequate laboratory, pathology, and radiology services in place to support timely and quality patient care. |  |  |  |  |  |
| * + 1. Availability of medical records system that documents the course of each patient’s illness, as well to support quality patient care, residents’ and fellows’ education, and quality assurance activities, and to provide a resource for scholarly activity. |  |  |  |  |  |
| * + 1. Access to appropriate food service 24 hours a day. |  |  |  |  |  |
| * + 1. The availability of adequate and appropriate call rooms or sleeping quarters that are safe, quiet, and private. |  |  |  |  |  |
| * + 1. The availability of appropriate security and personal safety measures at all locations including parking facilities, on-call quarters, hospital and institutional grounds, and related facilities. |  |  |  |  |  |
| **Component 2.2. Clinical governance/practices** | | | | | |
| * + 1. Effective clinical governance e.g. clinical committees and policies. |  |  |  |  |  |
| * + 1. Adequate number and mix of clinical teams. |  |  |  |  |  |
| * + 1. Appropriate education-service balance. |  |  |  |  |  |
| * + 1. Appropriate diversity of training experience, e.g. different levels of services. |  |  |  |  |  |
| * + 1. SI and participating sites is accredited by the Joint Commission International or by another entity with reasonably equivalent standards. |  |  |  |  |  |
| **Component 2.3. Learning/training resources** | | | | | |
| * + 1. Sufficient equipment and supplies for learning e.g. audio-visual aids, computers, data-show, laptop, white board, etc. |  |  |  |  |  |
| * + 1. Adequate IT infrastructure and systems. |  |  |  |  |  |
| * + 1. Access to specialty-/subspecialty specific and other appropriate reference material in print or electronic format. (Including electronic medical literature databases with search capabilities). |  |  |  |  |  |
| * + 1. Adequate setup and facilities for research. |  |  |  |  |  |
| **Component 2.4. Positive learning culture** | | | | | |
| * + 1. Flexible collegial environment for learning e.g. reward system and recognition. |  |  |  |  |  |
| * + 1. Policy and process for complaints and appeal by which individual residents and fellows can address concerns in a confidential and protected manner. |  |  |  |  |  |
| **OVERALL ASSESSMENT OF DOMAIN 2** |  | | | | |
| **Domain 3: Residents/fellows** | | | | | |
| **Component 3.1. Recruitment and deployment** | | | | | |
| * + 1. Policy on residents’ eligibility and selection is available. |  |  |  |  |  |
| * + 1. Participation in transparent match system. |  |  |  |  |  |
| * + 1. Policy on residents’ appointment (contracts) and recruitment is available. |  |  |  |  |  |
| * + 1. Hospital and GME orientation process in place. |  |  |  |  |  |
| * + 1. Residents participate in an educational program regarding physician impairment, including substance abuse and sleep deprivation. |  |  |  |  |  |
| **Component 3.2. Competency acquisition** | | | | | |
| * + 1. Supervision policy to ensure provision of safe and effective patient care and educational needs of residents and fellows |  |  |  |  |  |
| * + 1. Residency manuals addressing curriculum of training |  |  |  |  |  |
| * + 1. Mechanism for assigning progressive responsibility appropriate to residents and fellows’ level of education, competence, and experience |  |  |  |  |  |
| * + 1. Evaluation policy addressing formative assessment |  |  |  |  |  |
| * + 1. Mechanism/policy for resident mentorship is available |  |  |  |  |  |
| **Component 3.3. Training procedures** | | | | | |
| * + 1. Residents promotion and graduation criteria in alignment with NIHS bylaws |  |  |  |  |  |
| * + 1. Participation of residents in patient safety and quality of care education |  |  |  |  |  |
| * + 1. Mechanism/s to ensure compliance on policies and procedures addressing duty hours |  |  |  |  |  |
| * + 1. Procedures for residents transfer, freezing and withdrawal |  |  |  |  |  |
| * + 1. Policy for leave of absence |  |  |  |  |  |
| **Component 3.4. Resident support and growth** | | | | | |
| * + 1. Procedures to manage other learners. |  |  |  |  |  |
| * + 1. Access to learning resources and support. |  |  |  |  |  |
| * + 1. Resident participate on committees and councils whose actions affect their education and/or patient care. |  |  |  |  |  |
| * + 1. Forum for residents and fellows to communicate and exchange information on their educational and work environments, their programs, and other resident issues. |  |  |  |  |  |
| * + 1. Provision for leadership and career progression. |  |  |  |  |  |
| * + 1. Procedures for counselling and wellbeing. |  |  |  |  |  |
| * + 1. Policy to mitigate the risk of reduction and closure of programs and addresses administrative support for GME programs in the event of a disaster or interruption in patient care (should include assistance for continuation of resident/fellow assignments). |  |  |  |  |  |
| **OVERALL ASSESSMENT OF DOMAIN 3** |  | | | | |
| **Domain 4: Faculty and administrative staff** | | | | | |
| **Component 4.1. Scope and recruitment** | | | | | |
| * + 1. Presence of program organizational structure to support the residency training e.g. PD, APD, Faculty (core and non-core; physician and non-physician), coordinator etc. |  |  |  |  |  |
| * + 1. Availability of criteria for faculty eligibility and selection. |  |  |  |  |  |
| * + 1. Procedure for recruitment and job description. |  |  |  |  |  |
| * + 1. Hospital and GME orientation process in place e.g. faculty development training. |  |  |  |  |  |
| **Component 4.2. Support and growth of training team** | | | | | |
| * + 1. Provision for time, space, and equipment. |  |  |  |  |  |
| * + 1. Procedures for participation of faculty in evaluation and development of the residency program e.g. participation in program committees. |  |  |  |  |  |
| * + 1. Existing of faculty development program. |  |  |  |  |  |
| * + 1. Procedure in place for career progression and recognition. |  |  |  |  |  |
| **Component 4.3. Performance management of training team** | | | | | |
| * + 1. Performance appraisal system in place |  |  |  |  |  |
| * + 1. Procedures to support the faculty to balance between teaching and clinical activities |  |  |  |  |  |
| * + 1. The availability of institutional grievance policy including appeal procedure |  |  |  |  |  |
| **OVERALL ASSESSMENT OF DOMAIN 4** |  | | | | |
| **Domain 5: Continuous improvement and innovation** | | | | | |
| **Component 5.1. Internal review** | | | | | |
| * + 1. Existing policy and process for internal review. |  |  |  |  |  |
| * + 1. Issuance of internal review report by the internal review committee. |  |  |  |  |  |
| * + 1. Issuance of action plan for improvement by the reviewed program to be supported and approved by the GMEC. |  |  |  |  |  |
| * + 1. Periodicity of internal review is observed. |  |  |  |  |  |
| **Component 5.2. Quality improvement culture and system** | | | | | |
| * + 1. System for quality assurance in place. |  |  |  |  |  |
| * + 1. Documentation and reporting system in place e.g. clinical incidents reports, complaints, audits, tracers etc. |  |  |  |  |  |
| * + 1. Quality indicators reported across many clinical and administrative domains. |  |  |  |  |  |
| **Component 5.3. Change and innovation** | | | | | |
| * + 1. Existing resources for renewal and innovation. |  |  |  |  |  |
| * + 1. Socially responsive residency training. |  |  |  |  |  |
| * + 1. Existence of innovative initiatives and practices. |  |  |  |  |  |
| **OVERALL ASSESSMENT OF DOMAIN 5** |  | | | | |
| Overall assessment of all domains: |  | | | | |

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| **NAME** | **POSITION** | **SIGNATURE** |
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