Postgraduate Medical Council Of Victoria Inc.

2015 PMCV Accreditation Program Quality Review Report

March 2016

CONTENTS

List of Charts

1. INTRODUCTION

The Postgraduate Medical Council of Victoria Inc. (PMCV) accredits intern and reviews PGY2 training programs by assessment of the education and training provided for junior doctors in Victorian health facilities against a set of accreditation standards. The process has been in place for a number of years but in 2014, new national accreditation standards were adopted.

This report provides an analysis of the evaluation data collated for the accreditation survey visits conducted during 2015 and compares this to the evaluation data collated in 2014. The evaluation method used from 2014 is outlined in Appendix A.

1.1 Purpose of PMCV accreditation

The Medical Board of Australia has approved the Postgraduate Medical Council of Victoria Inc. (PMCV) as an intern training accreditation authority. In addition the Department of Health and Human Services has authorised PMCV to review postgraduate year two posts (PGY2).

The aim of accreditation, as it relates to prevocational medical training, is reflected in the following statement:

> *To develop, monitor and evaluate accreditation standards and processes that support education and training of JMOs and address any concerns about patient safety or JMO safety in a variety of clinical settings.* [1]

All facilities in Victoria that employ interns must be accredited by PMCV prior to their commencement and for PGY2s it is expected that facilities seek a quality review of these posts prior to commencement.

[1] Domain Statement, PMCV Strategic Plan 2016-2018, Domain 1: Accreditation and Standards.

2. EXECUTIVE SUMMARY – ACTION PLAN

Issue	Action
Encourage and support both junior doctor and senior medical staff attendance and participation at survey visit meetings (2014 issue).	• Data to be collated on meeting attendance by JMOs and SMS from 2016.
Meetings procedures not always adhered to including timing of meetings and professional behaviours (section 3.1).	• To be emphasised in team leader and surveyor training in 2016.
Formulation of recommendations that are both achievable and can be justified is important (section 3.1).	• Ensure recommendations for issues not raised previously within the health service are supported by examples. • Ensure recommendations can be implemented in the broader context.
Reporting of changes to posts can be time-consuming (section 3.1).	• Clarify the requirements in regards to reporting of changes to posts for interns and PGY2s.
Part-time internships have emerged as an important aspect of training. Facilities expressed some confusion in regards to accreditation requirements (section 3.1).	• Develop guidelines.
The documentation can be complex and time consuming to review by survey team members especially for large facilities (section 3.2).	• Ensure documentation is sorted appropriately when provided to survey team members.
Staff interviewed should be advised of accreditation outcomes (section 3.2).	• PMCV investigate ways to ensure staff interviewed (especially JMOs and SMS) are advised of accreditation outcomes following survey visits and mid-cycle reviews).
Survey team members indicated difficulties with accessing dropbox (section 3.2).	• Investigate a portal for collation of submissions and evidence.
Survey team members were not clear of the objectives of the facility tour (section 3.2).	• Clarify the objectives of the tour of the facility with team leaders (2016 forum).
Response rates for intern and PGY2 surveys for both visits and mid-cycle reviews could be higher across the facilities (section 3.4).	• Ensure JMOs are aware that the feedback is confidential (as PMCV requests facilities to send the survey link). • Consider other methods of collecting data.
Continue to emphasise the mandatory intern training requirements and the importance of clinical learning and supervisor interaction for PGY2s (section 3.4).	• Specific discussions during accreditation review processes.

3. ACCREDITATION PROGRAM EVALUATION FINDINGS 2015

3.1 Feedback from the facility

Feedback was collected from interviewees during visits, from facilities immediately after the visit and from facilities at the end of the end of the entire accreditation process. The data in the tables in this section represent the aggregate of all the feedback from the various groups.

During 2015, 11 survey visits were conducted (listed in Appendix B). Two of the visits were to assess new intern training programs which commenced in 2015 and a visit was conducted to Mansfield to assess two general practices for a new intern post to commence from 2016 under the auspices of the Murray to the Mountains intern program.

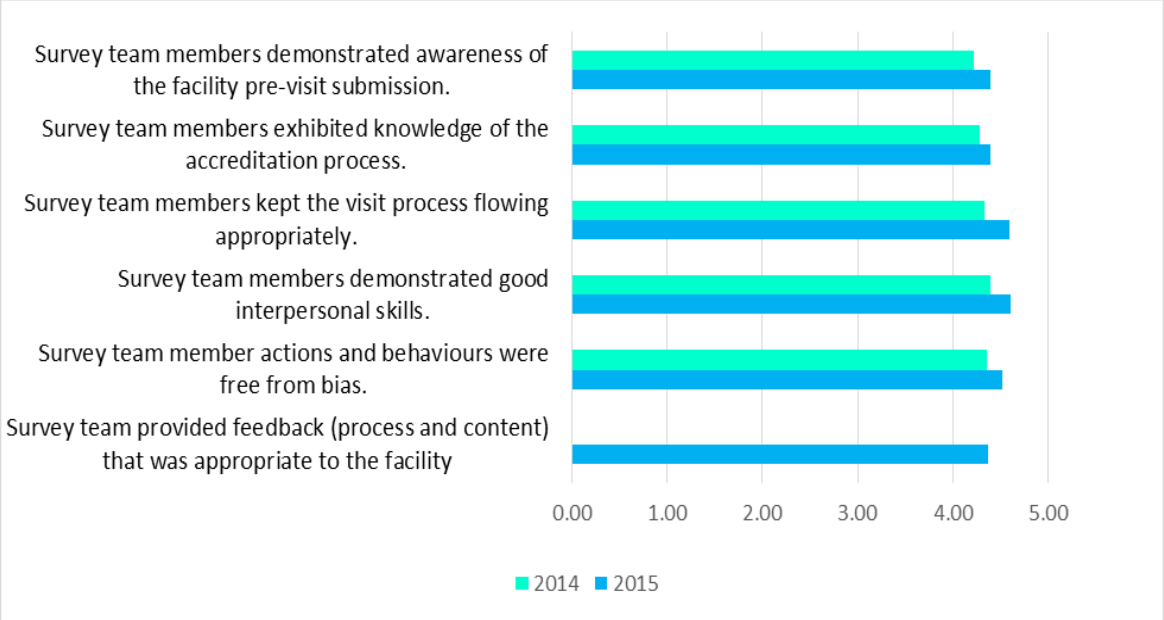
Interviewee feedback during visits

In 2015 interviewees from six facilities provided feedback (responses from six facilities were also received in 2014). Overall, in 2015 there were 134 junior doctors who responded (128 in 2014) and 47 senior medical staff who responded (33 in 2014).

In 2015, an additional question was included: *Survey team provided feedback (process and content) that was appropriate to the facility.*

Charts 1 and 2 provide a summary of the feedback received from junior doctors and senior medical staff for both 2014 and 2015. The feedback from both the junior doctors and the senior medical staff was positive in 2015 (as it was in 2014).

Chart 1: Junior doctor feedback during visits



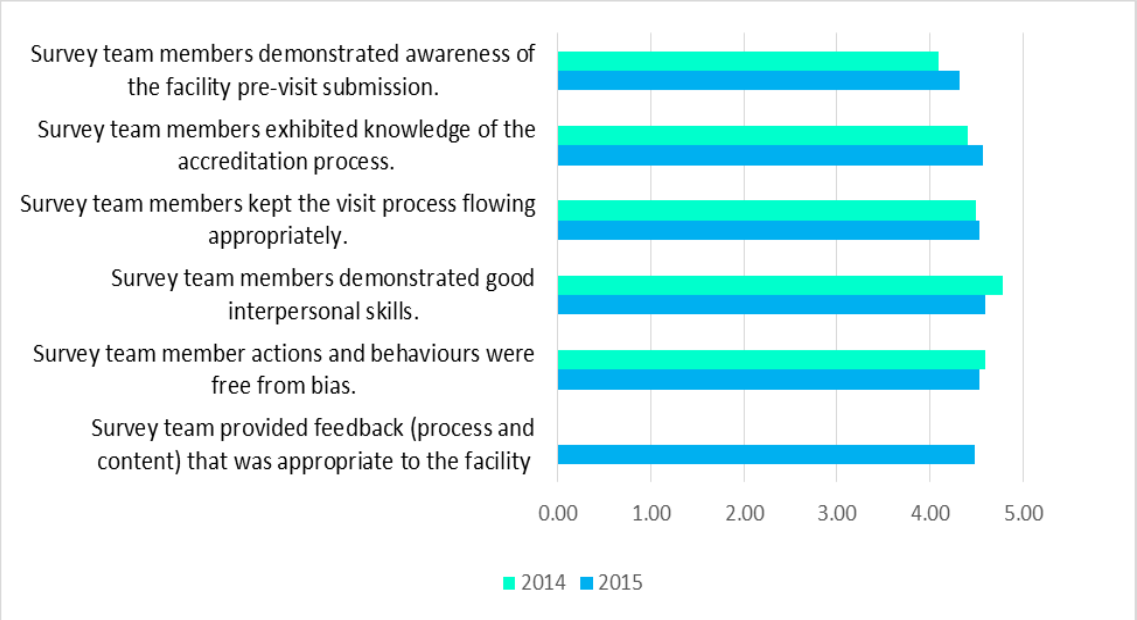
The junior doctors appreciated the opportunity to provide feedback and generally felt comfortable to be honest and open: *'Very friendly environment, I felt comfortable to share my experiences both good and bad* (intern respondent).

Another intern commented that it was '*Great to feel listened to - hopefully things change for future interns*!'

The senior medical staff also commented that the meetings were '*...open and constructive…*' and expressed appreciation for '*…helping us improve what we do*.'

One comment from one of the senior doctors was encouraging: *'Thank you. There has been much time spent preparing for the accreditation process and it is reassuring that this is not just a "rubber stamp" exercise, but one that will really benefit the future direction of our program for PGY1/PGY2s.'*

Chart 2: Senior medical staff feedback during visits



<u>Feedback from facilities at the end of the survey visit and the entire process</u>

Feedback from senior facility representatives was sought immediately following the survey visit and the data (combined for all facilities surveyed in that year) is shown in Table 3 for both 2014 and 2015. The response rate to this survey by facilities was 100% in both 2014 and 2015.

Generally, the feedback was positive confirming that:

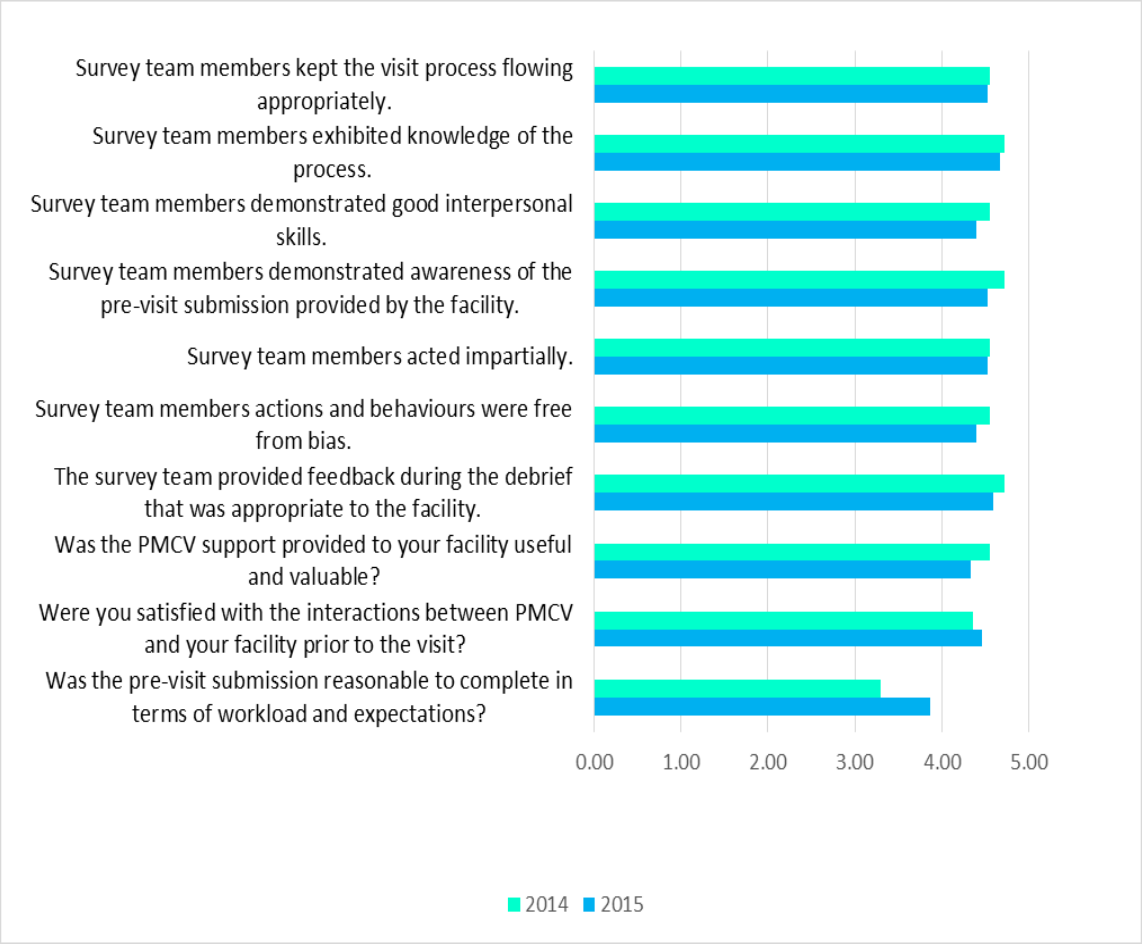
- The accreditation survey visit process is considered to be a valuable exercise by facilities which supports ongoing improvement.
- Facilities were satisfied that survey members contributed throughout the visit, and appeared to have an in depth knowledge of both the facility submission and the accreditation process.
- The conduct of survey teams was generally considered to be punctual and professional.
- Facilities were satisfied with the assistance and support provided by PMCV.
- Facilities generally felt that the purpose of the visits is to support improvement for the benefit of both junior doctors and the facility rather than being overly critical.

The feedback received did contain some criticisms including:

- Unprofessional behaviour towards a staff member at a facility being visited.
- Use of a smart phone by a survey team member during interview sessions at a visit.
- Perception that the tone of one of the visits was abrupt and unsupportive of the facility.
- Meetings generally kept to timetable however when meetings are brought forward this creates issues for the facilities trying to ensure all relevant staff can attend.

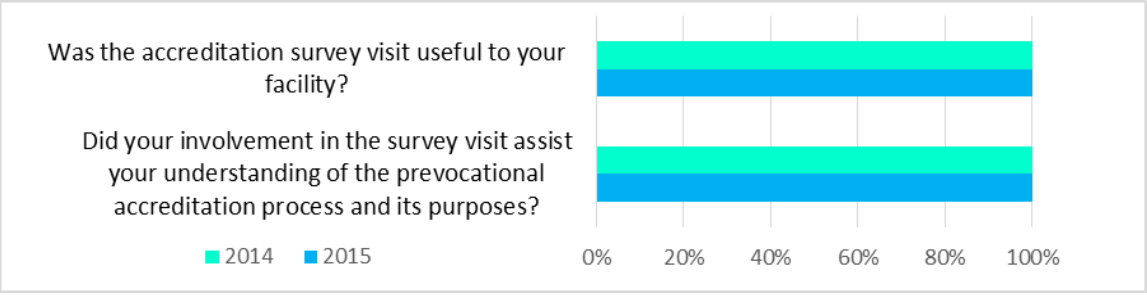
As in 2014, feedback indicated that completion of the pre-visit accreditation subcommittee was time-consuming and that some standards are repetitive. It was noted by one facility, however, that the suggestions explaining the standards on the initial accreditation document were very helpful. For 2016, there have been some revisions made to combine standards for the purposes of self-assessment and survey team rating.

Chart 3: Facility feedback immediately following visits



Feedback is also sought from the facilities at the end of the accreditation process when a response to the survey report (comments in relation to conditions and recommendations) is requested. Table 4 provides facility feedback in regards to the usefulness of the accreditation process.

Chart 4: Facility feedback at end of accreditation process



The general comments highlighted that the accreditation process is a useful quality improvement exercise, that it also served to support work by the facility in relation to areas for improvement already identified and that PMCV feedback is generally clear and concise. It was also noted that it is beneficial to have some team members who had been involved in previous visits to that facility as it provides for some continuity in relationships and knowledge.

*'The process of preparing for the accreditation visit was extremely helpful for identifying gaps and identifying opportunities for improvement to our program, and resulted in some positive changes that will result in sustained quality improvement.' (*facility representative)

Facilities offered some suggestions for improvement including:

- Where issues are flagged that have not been previously identified, it would be useful to receive examples of the practice(s) causing concern to assist with informing further changes.
- Some recommendations for change were not necessarily realistic due to conflicting constraints from other training bodies and that these limitations should be taken into account when the recommendations are reviewed at future accreditation surveys.
- The requirement to report every small change in regards to terms is difficult when facilities need to be flexible to meet changing business requirements which sometimes require redistribution of workforce in a relatively short timeframe.
- In regards to part-time internships, particularly where the JMO has a health issue, adjustment of approved training plans may be frequently required and reporting (of) every adjustment is time and resource intensive.
- Creating guidelines with thresholds for what changes facilities can make on their own and reporting to PMCV on an annual basis would assist facilities to meet operational demand as well as ensure that training and supervision is not impacted.

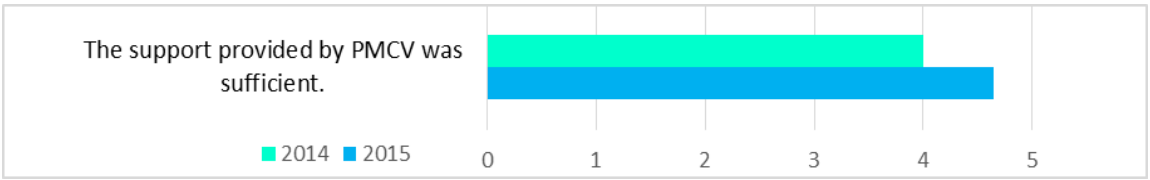
3.2 Feedback from surveyors

Following completion of all the survey visits in the current year, an electronic survey is sent to all surveyors who participated in visits during that year using *surveymonkey*. In 2015, there were 23 responses representing a 64% response rate (in 2014 there was a 90% response rate).

The survey was revised in 2015 into sections addressing PMCV support, preparation for the visit, the survey visit itself, the conduct of the team leader and any other suggestions for improvement. Some additional questions were also included (refer Appendix A, section 2).

Chart 5 shows the rating by survey team members for both 2014 and 2015 in regards to the support provided by PMCV. Generally the team members felt well prepared but it was suggested that a list of the documents being provided would be helpful.

Chart 5: PMCV secretariat support



Charts 6, 7 and 8 show the ratings by the survey team members for both 2014 and 2015 in relation to the overall conduct of the survey visit. The feedback was generally positive although the following points were specifically highlighted:

- The complexity and the commitment to reading information prior to the visit is huge, particularly for larger health services.
- The importance for surveyors to be current employees in the health system.
- The importance of focusing on the overall context.
- The necessity for staff interviewed to be advised of accreditation outcomes.
- The importance of broad representation on the survey team. As one respondent stated: '*Very fair assessment made of the facility I was part of the survey team for. It does help to have representation on the panel from a number of areas, including administration and those instrumental in the implementation of recommendations*.'

Chart 6: Feedback from survey team members – preparation for the visit

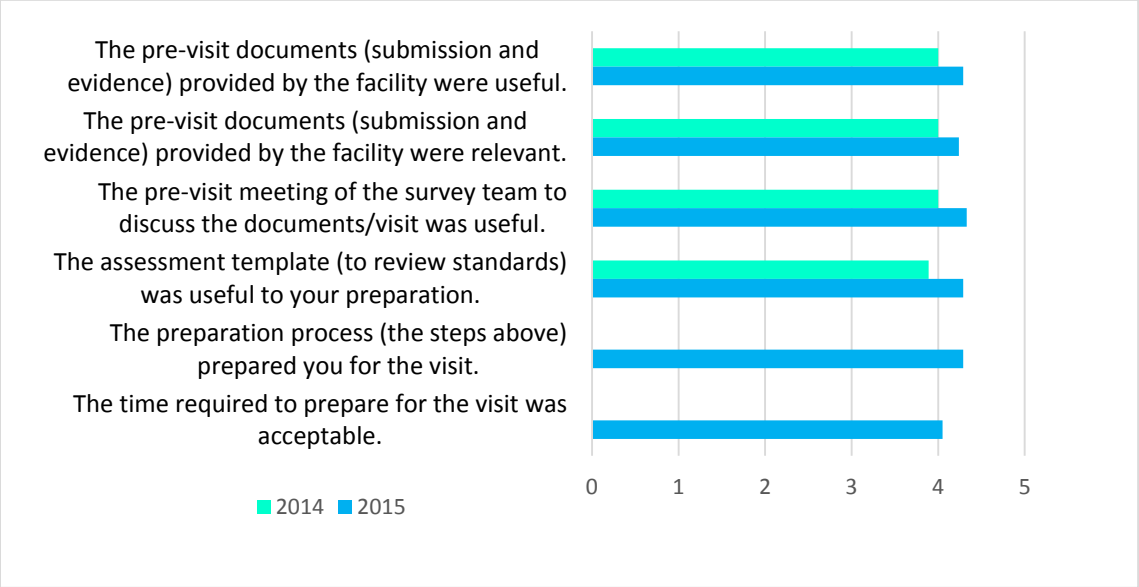


Chart 7: Feedback from survey team members – the survey visit

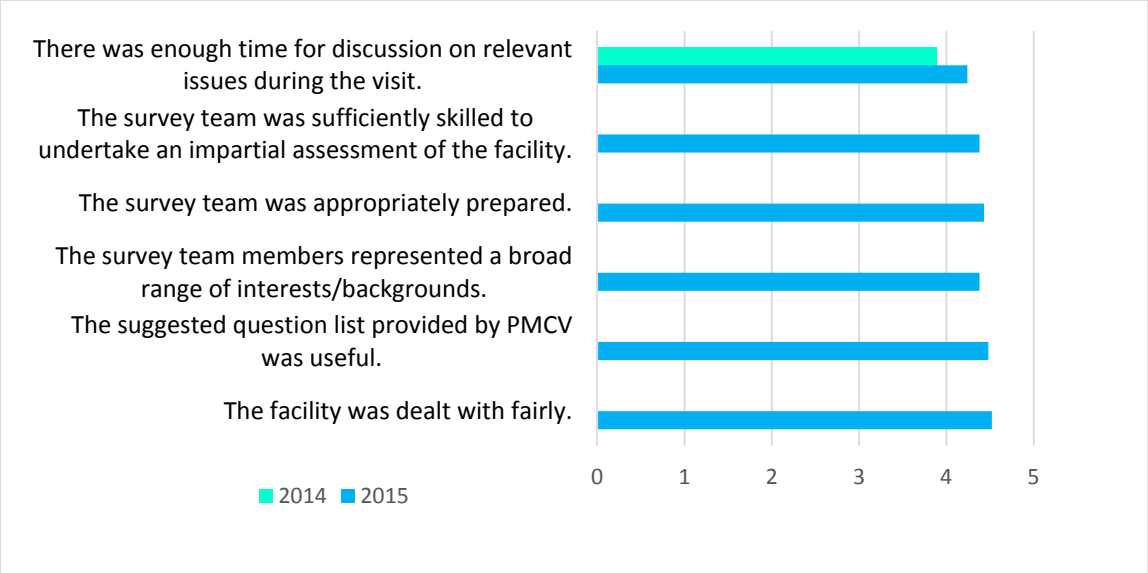
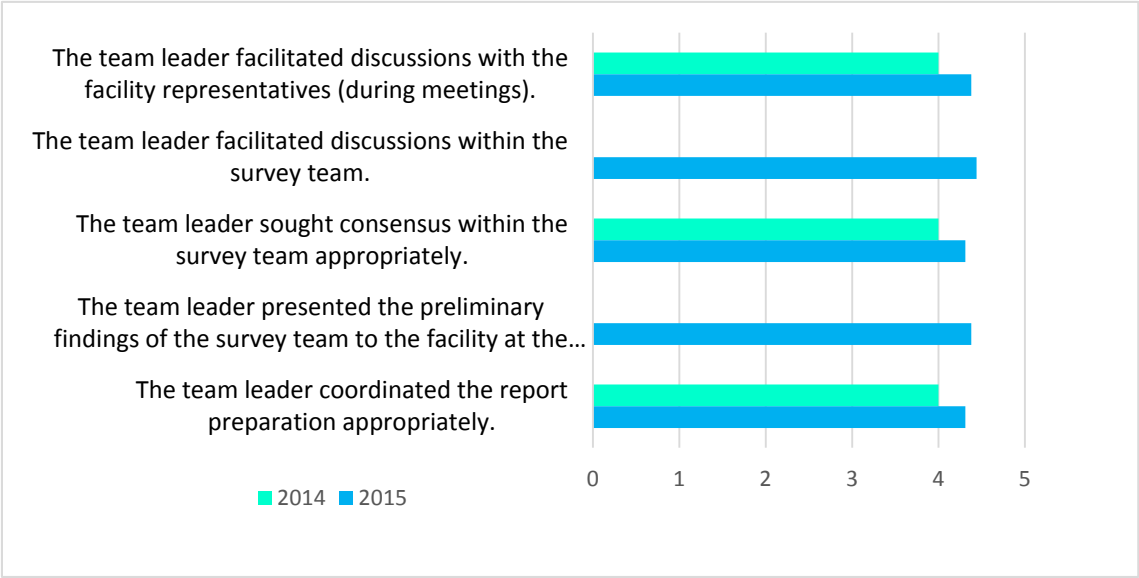


Chart 8: Feedback from survey team members – the team leader



There was one comments in relation to Table 8 which are important to address:

- '*Reports should be finalised on day of visit not a day later. We visited two facilities close by and left discussions to the end of total visit. Good notes helped but would have been easier to do on day while memory fresh*'.

Survey team members made a number of suggestions for improvement:

- In relation to the survey visit timetable, some team members considered there was too much time in between some meetings especially if work was done in advance. It should be noted that preparation of timetables is a challenge. At some visits the extra time is needed and at others not so much.
- '*Sometimes key people in the organisations being surveyed have left or are unavailable for various reasons. This can limit the insight the team has on the organisation. It would be useful if people such as these could be included in the interview process*.'
- The difficulty for some in accessing dropbox or similar due to internal restrictions by employing health services.
- *'When touring the facilities, I never really know if there's anything specific we're supposed to be looking for (I toured training facilities including simulation labs, and doctors' quarters).'*
- *'A brief report to the interns and PGY2's from the health service (who actually take the time to complete the survey) may be useful.'*

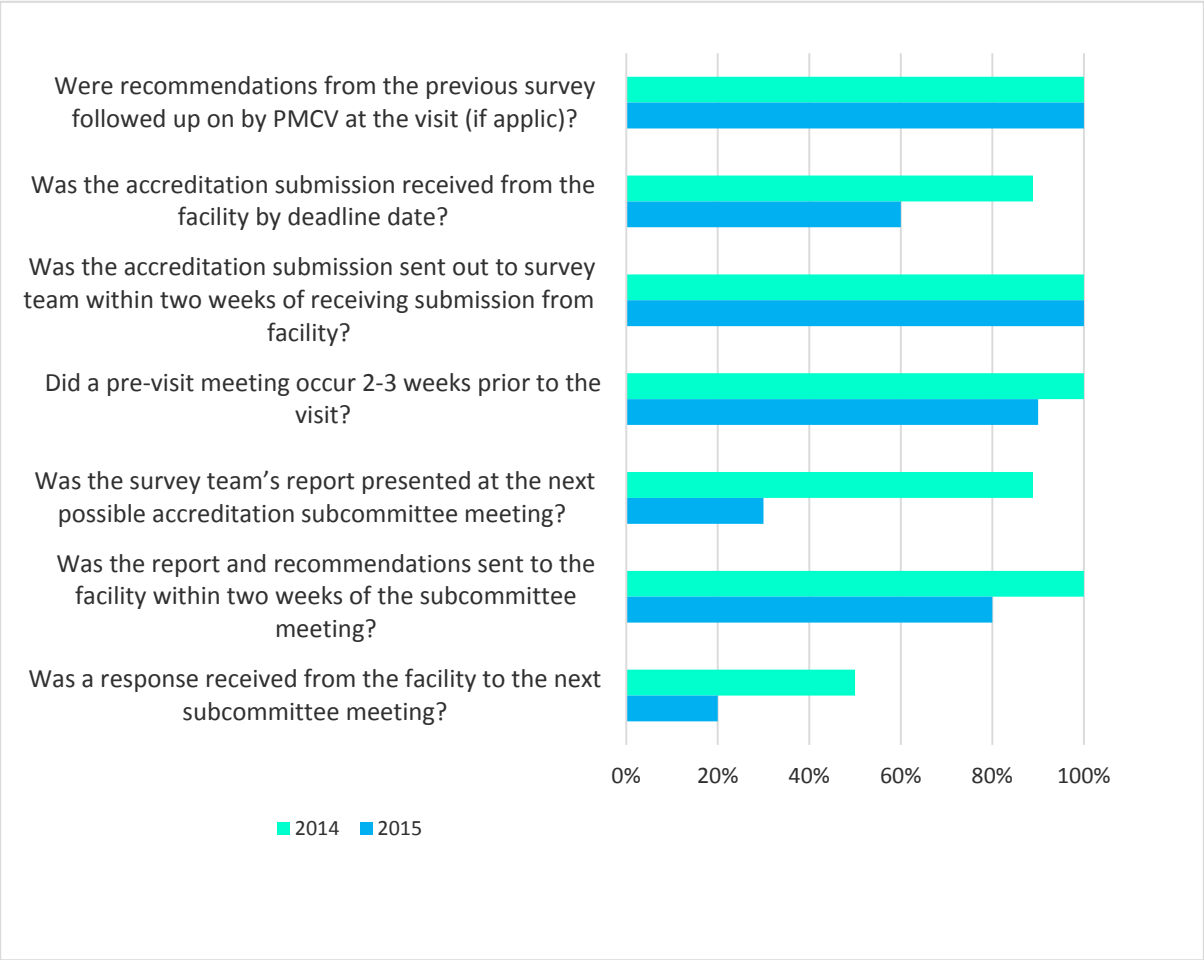
In regards to the overall accreditation process the following comment sums it up nicely:

'This is increasingly complex given our overall environment and the volunteer nature of many involved. The strength of support from the PMCV team is critical and without that we would do poorly. The level of support and understanding is exceptional and very much appreciated.'

3.3 Accreditation process timelines

Chart 9 shows the timelines for the nine visits conducted in 2014 and the ten visits in 2015.

Chart 9: Timelines for re-accreditation visits



In 2015, a number of timelines were not met for a variety of reasons.

The compliance with the deadline for submissions dropped from 90% in 2014 to 60% in 2015. Four of the ten facilities did not meet the deadline in 2015, however they did liaise with PMCV and met the revised deadline (usually a couple of weeks later). This did not delay the overall process at all with survey team members still having sufficient time to review the documentation prior to the visit.

Pre-visit meetings occurred for all visits in 2014 and all but one in 2015. It was determined that such a meeting was not required for this visit as it was a new accreditation and the submission had been reviewed at a subcommittee meeting with the team leader present.

Survey reports were completed and tabled at the next available subcommittee meeting for 90% of visits in 2014, but this dropped to 30% in 2015. The completion of survey reports is impacted by many factors including survey team interaction, timing of visits and subcommittee meetings and whether there are any issues that need to be addressed following the visit. It may not be achievable to table the report at the next meeting after a visit.

Further, in 2014, facility responses to the survey report were tabled at the next subcommittee meeting for only 50% of the visits, however responses were considered within two meetings. In 2015, only 30% of facility responses were considered at the next subcommittee meeting but this was due to a

change in the deadline for responses from two weeks to four weeks. All responses were received and reviewed within two meetings of the survey report being tabled in 2015.

Chart 10 provides the total length of time from receipt of facility submission to approval and distribution of survey report. The target is an estimate taking into account all deadlines and was increased in 2015 due to the facility response to report time being extended by two weeks.

It should be noted that if we calculate the period of time from the visit to the completion of the survey report, the length of time is between 60-70 days (about 10 weeks) except for one outlier where it took the survey team about a month longer to finalise the report. It would normally be expected that the report would be tabled at the subcommittee meeting within 6-8 weeks of the visit although it does depend on the timing the visit and how this coincides with the subcommittee meetings on the 3rd Monday of the month.

Chart 10: Time from submission to final report

Year	minimum	maximum	average	target
2014	83 days (12 weeks)	137 days (20 weeks)	107 days (15 weeks)	16-18 weeks
2015	68 days (10 weeks)	167 days (24 weeks)	120 days (17 weeks)	18-20 weeks

There were no appeals against accreditation decisions lodged in either 2014 or 2015.

3.4 Junior doctor feedback

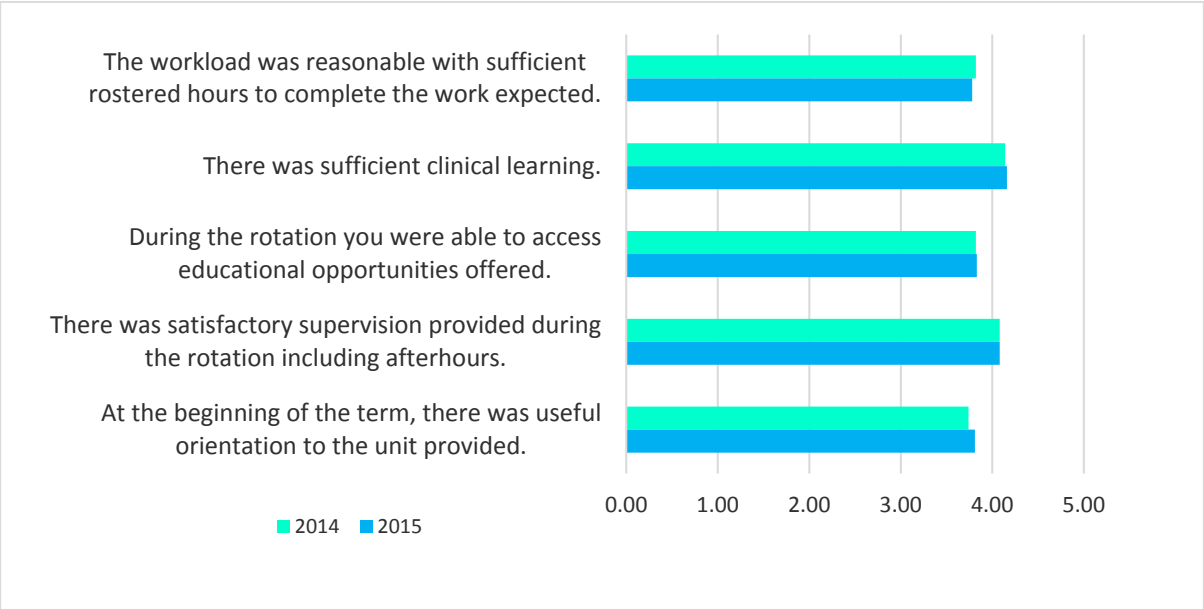
This section provides an overall summary of the feedback provided by junior doctors for the survey visits and mid-cycle reviews conducted in 2014 and 2015 (listed in Appendix B). Note that this feedback is provided by unit, but is aggregated in this analysis. In 2015, this data provides feedback on 17 facilities (around half of the total).

On average, the average response rate for the intern and PGY2 survey across all the facilities surveyed or which completed a mid-cycle review was 44% and 27% respectively in 2014. In 2015, the average response rate for both PGY1 and PGY2 surveys was around 47% representing a significant improvements in PGY2 responses. It should be noted that response rates for individual facilities range from 20% up to 75%.

The four charts in this section generally indicate consistent feedback across both 2014 and 2015 from the interns and the PGY2s in regards to all questions asked in the JMO survey. It is also pleasing to note that at least 85-90% of interns and PGY2s would generally recommend their rotations to colleagues (refer charts 13 and 14).

Charts 11 and 12 provide aggregate data on intern feedback on rotations in regards to orientation, supervision, education, clinical learning and rostered hours.

Chart 11: Intern feedback regarding rotations (aggregate)



The comments from interns provided both positive feedback as well as some identifying issues. As can be seen in Chart 13, more than 85% of interns would recommend their rotations to colleagues.

Interns articulated the factors which contribute to rotations which are highly regarded as follows:

- Exposure to a range of medical presentations and a diverse variety of patients where they can practice clinical skills and there is opportunity to participate in admissions.
- Rotations where consultants are approachable and supportive and with whom interns have regular interaction, particularly in terms of witnessing the decision-making process and feedback.
- Rotations where all staff are supportive, there is a positive team dynamic and the interns feel valued.
- It is important that there is a reasonable and manageable workload with an appropriate level of responsibility (balance of supervision and autonomy). Where workload is high, it is important that the senior staff recognise this and support the interns.
- Rotations where there are many opportunities to learn and supervisors who are keen to teach.

The issues identified by interns in 2015 were largely the same as for 2014. By far the main issue was that the time required to complete the expected volume of work often exceeds the rostered hours. This is especially prevalent in medical and surgical units where there is high levels of paperwork (e.g. discharge summaries) to be completed and where ward rounds and admissions can occur prior to or close to the end of a rostered shift which results in unrostered overtime being worked and limited access to clinical learning and education.

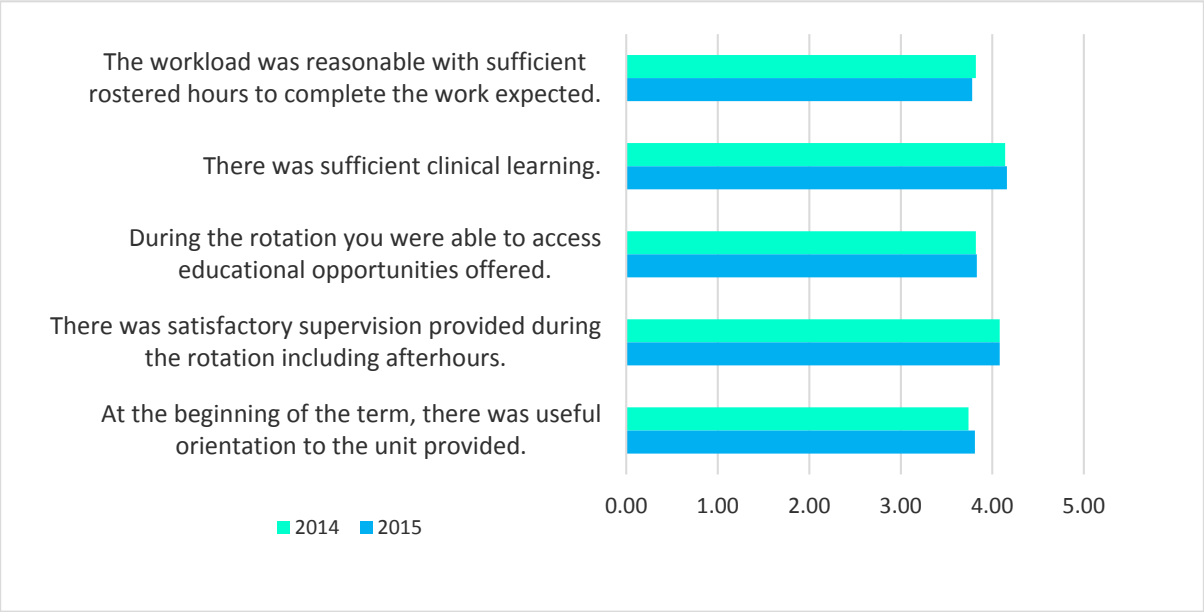
Other issues identified include:

- Access to education depends on the team/roster and interns indicated they would like more structured teaching in some units.
- Lack of consistency of supervisors (both registrars and consultants) negatively impacts on clinical learning. This can occur when supervisors constantly rotate or when they are not replaced for sick/other leave (especially registrars). This also impacts on the completion of performance assessments and provision of feedback.

- The identification of active term supervisors is an ongoing issue.
- Limited supervision and high workload when working after-hours (evenings/ weekends).
- The need for improved unit orientation. Where units have active term supervisors this seems to be less of an issue.

A further area of emphasis in 2015 was the completion of intern training requirements (core experiences) in mandatory terms such as access to theatre in surgery terms, admission experience in core terms, diversity of experiences in ED (e.g. across mainstream, fast track and SSU). Where such issues arose, survey teams generally opted to impose conditions on the facility to ensure that the intern training requirements are met.

Chart 12: PGY2 feedback regarding rotations (aggregate)



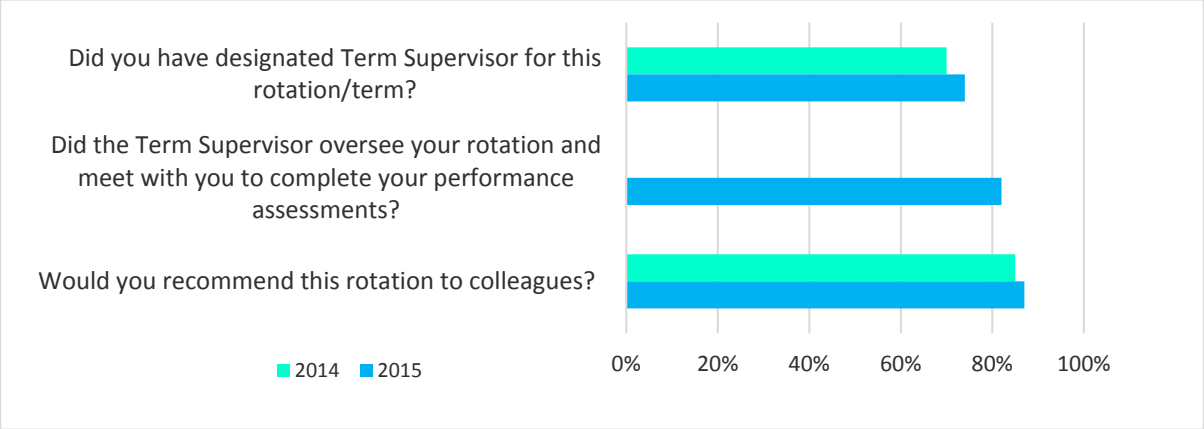
The PGY2 comments indicated that they appreciate rotations where they have access to learning and teaching with regular interaction with supportive senior staff. They also value working in a team where there is good communication and support and appreciate opportunities for increased autonomy and decision-making where there is a balance between independence and support.

The two main issues of concern to PGY2s are workload and supervision, especially afterhours. This is apparently often exacerbated by limited replacement of sick/other leave at both registrar and junior doctor levels. While PGY2s appreciate the opportunity to work more independently, they prefer to do so in a supportive environment where advice is easily accessible.

An issue that emerged in 2015 and is increasingly becoming important to PGY2s, is the allocation of terms with sufficient clinical learning and close interactions with senior supervisors to advance their skills and prepare them (both clinically and with references) for vocational training. PGY2s who are allocated nights or relief for significant periods of their year especially in the first six months are becoming increasingly concerned about the impact of such rotations on their eligibility for training programs.

Charts 13 and 14 show intern and PGY2 feedback in regards to term supervisors and whether or not JMOs would recommend their terms.

Chart 13: Intern feedback regarding term supervisors/recommend rotations (aggregate)

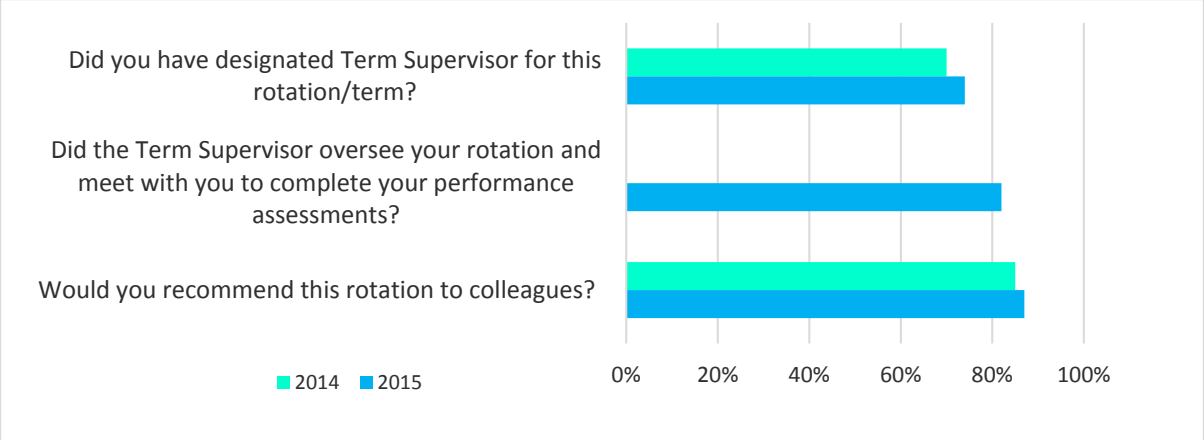


In 2014, this data indicates that 30-35% of JMOs could not identify a term supervisor[2]. At that time it was not clear whether this is due to the junior doctors being unaware of this role or that they do not know who is designated so the question was split in 2015 surveys as follows:

- Did you have designated Term Supervisor for this rotation/term?
- Did the Term Supervisor oversee your rotation and meet with you to complete your performance assessments?

In 2015, there seems to be an improvement in the percentages of JMOs, both interns (Chart 13) and PGY2s (Chart 14), being allocated a term supervisor which suggests that the emphasis on this issue by PMCV in the last 12-18 months appears to be working although it remains an ongoing issue for review.

Chart 14: PGY2 feedback regarding term supervisors/recommend rotations (aggregate)



[2] Defined as a medical practitioner designated to be responsible for the coordination of clinical training of interns and PGY2s rotating to that unit including intern orientation, monitoring and assessment.

3.5 Accreditation standard ratings

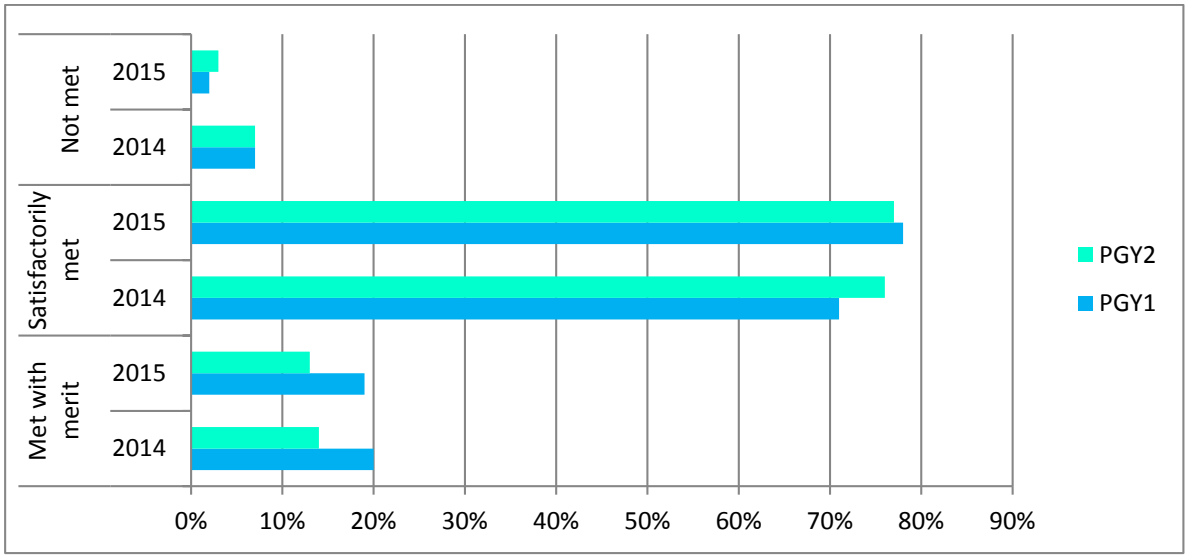
In 2014, PMCV implemented a new set of accreditation standards and a new three-point rating scale[3] which were also utilised in 2015.

Chart 15[4] provides aggregated rating outcome data for both 2014 and 2015 and clearly shows reasonable consistency in the ratings given across the facilities.

Note that the number of accreditation standards rated as *not met* in 2015 was half that compared to 2014 for both PGY1 and PGY2. This could be due to the training programs themselves being more prepared for the new accreditation standards or the mix of facilities visited (metro versus rural; established programs versus new programs) or 2015 survey teams being more reluctant to rate facilities as *not met.*

As for 2014, facilities re-accredited in 2015 *satisfactorily met* or *met with merit* at least 90% of the accreditation standards with slightly more standards *met with merit* for intern training programs compared to PGY2 programs.

Chart 15: Ratings by survey teams for PGY1 and PGY2 assessment



An analysis of the accreditation standards *not met* was undertaken for the facilities re-accredited in 2015 and these varied across the facilities.

- In 2014 multiple facilities did not meet Standard 1.2.2 which requires facilities to advise PMCV of changes to posts and in 2015 another two facilities also received a recommendation on this topic.
- As for 2014, in 2015 two facilities did not meet Standard 5.1.4 (using junior doctor assessment data to improve the program) which may reflect ongoing confusion in regards to the intention of this standard.
- Standard 1.2.3 (effective operational structures), Standard 7.4.1 (junior doctors to be informed of the activities of committees which deal with their training) and Standard 7.2.2 (access to career advice) were not raised as issues in 2015 as they were for 2014.

[3] Met with merit, satisfactorily met and not met

[4] In 2014, there were seven facilities with intern training re-accredited and 5 facilities with PGY2 training programs and in 2015 there were nine facilities with both intern and PGY2 training programs although two are intern rotation sites and one the ratings for PGY2 posts were not completed and will be reviewed in 2016.

- Standard 7.2.1 which relates to JMO welfare and support emerged in 2015 as an issue perhaps due to the increasing focus on this as a consequence of bullying and harassment. The AMC has indicated that this area will be of increasing focus in the accreditation standards from 2016.

Other standards that some facilities struggled to meet in both 2014 and 2015 included:

- Standard 3.1.3b: Unit orientation was a theme in the recommendations for both years however most facilities were still rated as *satisfactorily met* because while some units do this well, this is not consistent.
- Standard 4.1.2: The majority of facilities do support JMOs to attend education but with competing demands on their time this support needs to be explicit, especially for interns.
- Standard 5.2.7: A new requirement of the AMC intern training guidelines is the establishment of Intern Assessment Review Panels. Different models are being implemented across Victorian facilities. The Education subcommittee is developing a survey to understand the nature of the IPAPs and remediation provided.
- Standard 6.2: Facilities exhibit varied success in engaging supervisors in the JMO training programs especially in relation to program monitoring (feedback) and development.
- Standard 7.3.1: The involvement of JMOs in the governance of their training is an ongoing issue. At some facilities this can be difficult to achieve in a formal way due to high numbers of rotating staff however it is important to engage JMOs in providing feedback to inform the development of their training programs.

3.6 Commendations, conditions and recommendations

This section provides a thematic analysis of the commendations, conditions and recommendations outlined in the survey reports for facilities re-accredited in both 2014 and 2015.

Commendations

In 2015, there were a range of commendations particularly in the following areas and these correlated with those identified in 2014. Interestingly, the number of commendations increased markedly from 2014 to 2015 with JMO support and education being the areas most commended.

- Junior doctors feel supported and have access to good quality, hands-on clinical learning. Performance management processes are reasonably robust.
- Facilities generally provide high quality education and teaching which is well regarded by junior doctors who are supported to participate.
- Senior consultants generally exhibit goodwill and engagement and ensure they are approachable to junior doctors.
- Facilities generally exhibit a clear vision, satisfactory organisational structures and a culture of teaching and education.
- Many facilities continue to be engaged in roster redesign to address issues regarding the workload of junior doctors.

Conditions

Conditions to ensure compliance with the accreditation standards were applied to eight of the nine facilities re-accredited in 2015.[5]

The conditions identified in 2015 correlated closely with those in 2014 with the vast majority of conditions being concerned with ensuring clinical learning and supervision of interns in mandatory terms meets training requirements. The main issues were:

- Appropriate supervision structures which reflect the type of core term;
- Core intern training posts must provide broad experience and regular exposure to admissions (for core medicine) and theatre (for core surgery) where it is preferable that attendance at theatre is rostered;
- Where admitting units (either surgery or medicine) exist, that facilities ensure that interns receive a broad exposure to general medicine or surgery experience; and
- Where short stay units exist in emergency, that interns are rostered for no more than 50% of their time in a core term in SSU.

In addition, one facility was required to establish an Intern Assessment Review Panel (standard 5.2.7) and one facility in 2015[6] was required to review intern cover of units which were not accredited for intern training.

Recommendations

A comparison of the quality improvement recommendations made by survey teams in 2014 and 2015 indicate that the themes were generally consistent.

There were some themes identified in 2014 which seem to have been more effectively addressed in 2015 including the identification of term supervisors, advice to PMCV of new posts and changes to posts and junior doctor involvement in program governance.

However, some themes were more prevalent in 2015 such as performance management (including certification of internship and support for junior doctors experiencing difficulties), access to education for PGY2s and supervision of junior doctors.

In regards to supervision, for which recommendations increased markedly from 2014 to 2015, the areas for improvement identified included capability and level of supervision and appropriateness of intern cover in some areas e.g. HDU and supervision in some units especially subacute wards. Further, a new issue emerged in relation to supervision of junior doctors, especially interns, in the mental health tribunal process resulting in the development of guidelines by the PMCV Accreditation subcommittee in relation to preparation of reports and attendance at tribunals by junior doctors which were incorporated into the *PMCV Supervision of Junior Doctors Guidelines*.

The other main areas for improvement fall into the following broad themes:

- Junior doctor welfare issues such as management of doctors in difficulty.
- Orientation, especially to clinical units at the beginning of term and to other sites.
- Rostering and workload, particularly ensuring that rostered hours reflect the actual hours being worked and workload at times of reduced staffing (e.g. evenings, weekends and nights).
- Program feedback and evaluation.

[5] Five of the eight facilities assessed for re-accreditation in 2014 received conditions.
[6] There was also one facility in 2014.

4. 2014 ACCREDITATION PROGRAM EVALUATION OUTCOMES

In 2015, a number of changes occurred as a consequence of the evaluation of the 2014 accreditation program as follows:

Issue	Action	Outcome
Pre-visit preparation and documentation:		
Feedback indicated that the pre-visit preparation was a lot of work for facilities.	This is acknowledged and the Accreditation Manager will continue to work with facilities to streamline this process.	This continued to be a factor in 2016 and difficult to balance with being rigorous. It is anticipated that this will improve in the next accreditation cycle as facilities become more familiar with the documentation.
It was noted that there is a fair degree of repetition in the standards and it was suggested they need to be streamlined.	While the accreditation standards cannot be changed, it is apparent that repetition could be addressed by review of the evidence required to meet standards. This will be discussed at the Team Leaders workshop in February 2015.	A review was undertaken prior to the 2016 accreditation program to aggregate some repetitive accreditation standards where possible for the purposes of self-assessment and survey team ratings.
The same pre-visit document was used for applications for accreditation of new programs and re-accreditation which was confusing.	Review the pre-visit submission and remove certain items not relevant to new programs e.g. Section 2 which deals with recommendations from a previous visit and the ratings rows in Section 3 where new programs are required to comment on how they intend to meet the standards.	During 2015, submission documents were created specifically for each facility which addressed this issue.
30-35% of junior doctors could not identify a term supervisor. It is not clear whether this is due to the junior doctors being unaware of this role or that they do not know who is designated.	JMO survey question to be reviewed to ensure this ambiguity is addressed.	An additional question was included in the survey: D*id the Term Supervisor oversee your rotation and meet with you to complete your performance assessments?*
It was suggested that facilities be provided with a longer timeframe to respond to the recommendations in the survey report.	This was an issue in 2014 due to the late commencement of the accreditation program. Visits in 2015 will occur from May to September and the timelines will be reviewed to allow a longer response time (currently two weeks).	In 2015, the time provided for response to the survey was increased from two weeks to a month. This worked well for facilities but extended the timeline for completion of the overall accreditation process.

Issue	Action	Outcome
During the survey visit:		
There was confusion expressed regarding the length of meetings.	Ensure that the meetings are advertised and expectations clearly explained to attendees.	Following the review and development of an *information sheet* for interviewees, the length and timing of meetings generally worked well in 2015.
There was an identified need to further encourage and support both junior doctor and senior medical staff attendance and participation at survey visit meetings.	The Accreditation Manager to work with facilities on this point.	Participation by JMOs and SMS in meetings in 2015 was generally good although some facilities struggled. This will continue to be emphasised in 2016. Data collation on this point to commence in 2016.
First time surveyors felt supported although it was suggested that, in addition to surveyor training, that new surveyors could attend their first visit as an observer.	This to be trialled in 2015.	This was successfully implemented in 2015 (assisted by a reduced number of annual visits) and will be continued in 2016.
A tool be developed that lists the various themes that often come up which surveyors could then insert comments into rather than scribbling notes and trying to piece these together later.	There are currently two tools available. • A table of the standards with relevant issues/ questions to be addressed with room to comment. • A list of the questions to be asked during specific meetings to ensure sufficient information is collated for all standards. Both of these will be made available to survey team members in 2015.	The question list was revised and is reviewed for each facility following the pre-visit meeting. This issue was not raised in 2015.

Issue	Action	Outcome
Accreditation decisions and outcomes:		
That there needs to be consideration given to accreditation of the internship year to meet mandatory intern training requirements rather than being limited core terms, as long as longitudinally the year fulfils the core emergency medicine, general medicine and general surgery requirements of intern training.	The new *PMCV Accreditation of Intern Terms Guidelines* have been developed to be flexible enough to consider alternative intern training models.	This issue was not raised in 2015. The guidelines developed assisted survey teams to focus on the meeting of mandatory intern training requirements.
Issues raised by junior doctors included access to education, rostered hours being insufficient to complete work expected, inconsistency of supervision and limited supervision after-hours, and the need for unit orientation to be improved. 30-35% of junior doctors could not identify a term supervisor.	See recommendations for quality improvement (section 3.6).	Recommendations in relation to these issues were also made in 2015 however the availability of term supervisors seems to have improved (section 3.4).

APPENDIX A: EVALUATION METHOD

Three levels of evaluation of the accreditation process are undertaken:

i. Feedback from the facility.

ii. Feedback from survey team members.

iii. Timelines in relation to the accreditation process are monitored.

This is supplemented by an analysis of survey visit outcomes including:

iv. Analysis of feedback from junior doctors.

v. Analysis of accreditation standard ratings for each facility/ training program.

vi. Thematic analysis of commendations, conditions and recommendations in survey reports.

1. Feedback from the facility

Feedback from the facility is collated during the visit, immediately following the survey visit and at the completion of the entire accreditation process.

<u>During the visit</u>

A paper survey is distributed at the end of meetings during the visit to obtain feedback on the overall performance of the survey team from all those interviewed on the day with the following questions:

i. Survey team members demonstrated awareness of facility pre-visit submission.
ii. Survey team members exhibited knowledge of the accreditation process.
iii. Survey team members kept the visit process flowing appropriately.
iv. Survey team members demonstrated good interpersonal skills.
v. Survey team member actions and behaviours were free from bias.

<u>Following the visit</u>

A survey is sent using *surveymonkey* to the nominated contact/Director of Medical Services for the facility to complete immediately following the visit using the questions in the section above in addition to the following:

vi. The survey team provided feedback during the debriefing to the facility that was appropriate to the facility.
vii. Was the PMCV support provided to facility useful and valuable?
viii. Were you satisfied with the interactions between PMCV and your facility prior to the visit (e.g. selection of dates, timetable)?
ix. Was the pre-visit submission reasonable to complete in terms of workload and expectations?
x. Any other comments.

<u>At the end of the accreditation process</u>

Evaluation feedback is also sought from the facility at the end of the process using the *response to survey report form*.

i. Was the accreditation survey visit useful to your facility (e.g. was it a useful quality improvement exercise)?
ii. Do you have any suggestions for improvement in regards to the PMCV accreditation process/ standards?
iii. Did your involvement in the survey visit assist your understanding of the prevocational accreditation process and its purpose?
iv. Any other comments in regards to the PMCV accreditation process/ standards.

2. Feedback from survey team members

In November of the year of the accreditation program, a survey is conducted using *surveymonkey* to seek feedback from surveyors who participated in accreditation visits during the current year.

The survey questions in 2015 (revised from 2014) were:

i. The support provided by PMCV was sufficient.
ii. Are there any aspects of the accreditation survey visit process which could have been managed better or can you suggest any improvements to the overall process?

Pre-visit preparation

iii. The pre-visit documents provided by the facility were useful.
iv. The pre-visit documents provided by the facility were relevant.
v. The pre-visit meeting of the survey team was useful.
vi. The assessment template (to review the standards) was useful.
vii. The preparation process (ii – v) prepared you for the visit.
viii. The time required to prepare for the visit was acceptable.

The survey visit

ix. There was enough time for discussion on relevant issues during the visit.
x. The survey team was sufficiently skilled to undertake an impartial assessment of the facility.
xi. The survey team was appropriately prepared.
xii. The survey team members represented a broad range of interests/backgrounds.
xiii. The suggested question list provided by PMCV was useful.
xiv. The facility was dealt with fairly.

Conduct of team leader

xv. The team leader facilitated discussions with the facility representatives.
xvi. The team leader facilitated discussions with the survey team.
xvii. The team leader sought consensus with the survey team appropriately.
xviii. The team leader presented the preliminary findings of the survey team to the facility at the end of the visit appropriately.
xix. The team leader coordinated the report preparation appropriately.

3. Accreditation process timelines

The following accreditation process timelines are monitored:

i. Were the recommendations from the previous survey followed up on by PMCV at the visit?
ii. Was the accreditation submission received from the facility by deadline date?
iii. Was the accreditation submission sent out to the survey team (with JMO survey results and previous survey visit report) within two weeks of receiving submission from facility?
iv. Did a pre-visit meeting occur 2-3 weeks prior to the survey visit?
v. Was the survey team's report presented at the next possible Accreditation subcommittee meeting?
vi. Was the report and recommendations sent to the facility within two weeks of the subcommittee meeting?
vii. Was a response received from the facility to the next subcommittee meeting?
viii. What was the total length of time from the accreditation submission to the sending of the final report?
ix. If relevant, was the facility appeals process started within 14 days of report being sent and coordinated smoothly?

In general, for re-accreditation visits it is expected that:

- The pre-visit submission be received by PMCV two months prior to the visit and forwarded to the survey team within two weeks.

- The pre-visit meeting should occur 2-3 weeks prior to the visit.
- The draft report be prepared for review by the survey team within two weeks of the visit and that this report be tabled at the next available subcommittee meeting.
- The survey report then be forwarded to the facility for a response within two weeks of the subcommittee meeting where it was approved and a response be provided to the next subcommittee meeting.

For accreditation of new programs, it is expected that PMCV be notified six months in advance to begin the process of accreditation.

4. Junior doctor feedback

A survey of junior doctors is conducted using *surveymonkey* prior to the survey visit to obtain specific feedback in regards to terms:

i. The workload was reasonable with sufficient rostered hours to complete the work expected.
ii. There was sufficient clinical learning (including access to acute, undifferentiated patients and experience of admission, ongoing management and discharge).
iii. During the rotation you were able to access educational opportunities offered (e.g. tutorials, unit meetings, grand rounds, clinical skills training).
iv. There was satisfactory supervision provided during the rotation including afterhours (evenings/weekends).
v. At the beginning of the term, there was useful orientation to the unit provided.
vi. Did you have designated Term Supervisor(s) for this rotation/term (who was responsible for your assessments and interacted with you regularly)?
vii. Would you recommend this rotation to colleagues?

5. Accreditation standard ratings

During the re-accreditation process, the facility undertakes a self-assessment against the accreditation standards. Following the visit, the survey team then determines ratings against these standards. Assessment uses a three-point rating scale:

- *Not Met* – criteria have not been achieved within standard
- *Satisfactorily met* – criteria have been achieved
- *Met with merit* – in addition to achievement of the criteria, there is a higher level of achievement evident e.g. a culture that strongly supports education, supervision, evaluation and improvement in junior doctor training programs.

6. Commendations, conditions and recommendations

Following a survey visit, the survey team prepares a report which includes commendations, conditions and recommendations in relation to the prevocational medical training program.

Commendations arise from aspects of the training program which the survey team identifies as met with merit.

Conditions are generally applied to programs or posts to ensure minimum training requirements are met and are usually expected to be implemented within 3-6 months.

Recommendations made by the survey team encourage continuous improvement of junior doctor training and are reviewed during the mid-cycle review and at the next survey visit.

APPENDIX B: 2015 SURVEY VISITS AND MID-CYCLE REVIEWS

2015 Survey Visits

- Bairnsdale Regional Health Service/ MacLeod Street Medical Centre
- Bendigo Health/ St John of God Hospital Bendigo
- Central Gippsland Health Service and Clocktower Medical Centre (Sale)
- Central General Practice (Mansfield)/ Mansfield Medical Clinic (M2M)
- Echuca Regional Health/ Echuca Moama Family Medical Practice
- Latrobe Regional Hospital
- Monash Health
- Northeast Health Wangaratta
- Royal Children's Hospital
- West Gippsland Healthcare Group

2015 Mid-cycle Reviews

- Alfred Health
- Austin Health
- Bass Coast Regional Health
- Eastern Health
- Goulburn Valley Health
- Northern Health
- Werribee Mercy Hospital
- Western Health
- Wimmera Health Care Group

2014 Survey Visits

- Ballarat Health Services
- Mildura Base Hospital
- Murray to the Mountains
- Peninsula Health
- Royal Melbourne Hospital/Royal Women's Hospital
- Western Health
- Wimmera Health Care Group

2014 Mid-cycle Reviews

- Bendigo Health
- Latrobe Regional Hospital
- Peter MacCallum Cancer Centre
- Royal Children's Hospital
- Swan Hill District Health
- Werribee Mercy Hospital