Hospital Accreditation Regulations

For the Surgical Education and Training Program in Vascular Surgery

Approved: 21 June 2018

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1 Introduction

1.1 Definitions and Terminology

The following terms, acronyms, abbreviations, and their associated definitions will be used throughout these Regulations:

Term	Definition
ANZSVS	Australian and New Zealand Society for Vascular Surgery
Board (the)	Board of Vascular Surgery
BSET	Board of Surgical Education and Training
Post	Training position accredited by the Board of Vascular Surgery
RACS	Royal Australasian College of Surgeons
SET	Surgical Education and Training
Supervisor	The Surgical Supervisor is a consultant surgeon in a hospital with accredited Trainees. The Surgical Supervisor is appointed and approved by the Board and BSET and is a member of the ANZSVS.

1.2 Overview

1.2.1 These Regulations establish the terms and conditions for the assessment and accreditation of training posts the SET Program in Vascular Surgery. These Regulations are compliant with the policies of the Royal Australasian College of Surgeons.

1.2.2 Hospital Accreditation and the ensuing approval process are undertaken to ensure the suitability of units for the SET Program in Vascular Surgery.

1.2.3 Training for the SET Program in Vascular Surgery is undertaken in accredited training posts.

1.2.4 The information in these regulations is subject to change at any time. The most current version is published on the RACS website.

1.2.5 The Vascular Surgery SET Program is governed by the Vascular Surgery Training Program Regulations available on the RACS website.

1.3 Administration

1.3.1 RACS is the body accredited and authorised to conduct SET Training in Australia and New Zealand.

1.3.2 The administration of the Vascular SET Program, including hospital accreditation, is delegated to the Australian and New Zealand Society for Vascular Surgery in accordance with the Partnering Agreement.

1.3.3 RACS has approved policies and procedures that should be read in conjunction with these Regulations.

2 Accreditation

2.1 Criteria

2.1.1 The Board of Vascular Surgery adheres to the RACS Hospital Accreditation criteria and has an abbreviated application specific to Vascular Surgery.

2.1.2 The following information will also be reviewed as part of accreditation:

a. A schedule of each Trainee's clinical day-to-day program
b. A schedule of Unit and interdisciplinary educational meetings

2.1.3 In addition, the following criteria apply:

a. Vascular Surgery Trainers

Each unit must have two Vascular surgery trainers (FRACS or are certified as equivalent) at a minimum. Failure to meet these criteria may result in the unit being un-accredited. In addition to the requirements of the Surgical Supervisor set out in the Board's supervisor's handbook, all surgeons on the unit must have completed:

- RACS Foundation Skills for Surgical Educators course
- RACS Operating with Respect e-learning module

b. Unit Caseload and Case mix

Major Vascular surgery procedures are listed on the RACS website and in the in-training assessment form. Each training post must be able to provide a minimum of 100 major cases per year. The trainee must be the primary operator a percentage of the time in accordance with their SET level as detailed below.

SET 1	N/A
SET 2, first six months	20%
SET 2, second six months	25%
SET 3, first six months	30%
SET 3, second six months	40%
SET 4, first six months	50%
SET 4, second six months	50%
SET 5, first six months	60%
SET 5, second six months	60%

2.1.4 If any of the above requirements are found to be deficient the Board will request the deficiency rectified in a specified timeframe. If the deficiency is not rectified the accreditation may be removed.

2.1.5 Applications for accreditation should be submitted to the Board of Surgery via email or post.

2.2 Classification and Approval

2.2.1 Posts will be accredited either as SET 1 or SET 2+. A SET 2+ signifies that the post is suitable for trainees across SET levels 2-5.

2.2.2 Posts will be accredited for a set time period between one and five years.

2.2.3 A post will be accredited as either full-time or less than full-time.

2.2.4 The last possible meeting at which the Board of Vascular Surgery will approve hospital accreditation recommendations for the following year will be the June meeting. This is to ensure that recommendations can be approved at BSET and allow trainee allocations to be made in a timely manner.

2.2.5 Applications for accreditation are to be submitted by 31 January. Failure to complete the application by this date may result in the post not being inspected, delay in accreditation, and a vacant post during the delayed period of accreditation.

2.3 Probationary Accreditation and Withdrawal of Accreditation

2.3.1 The Board may review the accreditation status of a post at any time.

2.3.2 Probationary accreditation indicates the accreditation status is under review and is usually for a period of twelve (12) months.

2.3.3 While probationary accreditation is applied, the hospital may be unable to host trainees.

3 Application Type

3.1 New Training Post

3.1.1 To be considered for a training post, applications must be received no later than 31 January in the year prior.

3.2 Quinquennial

3.2.1 The Board inspects most training posts on a five-yearly cycle. Inspections are conducted in the year the accreditation validity ends.

3.2.2 Hospitals will be contacted in November of the preceding year regarding the scheduled inspection, and must submit an application for accreditation by the 31 January the year of the inspection.

3.3 Re-inspection

3.3.1 The Board may initiate a re-inspection at any time if an area of concern is identified which requires further investigation or if there has been a major change in circumstances. In such circumstances the Board will communicate the reason for the re-inspection in writing.

3.3.2 Hospitals will be required to submit a new application and supporting documentation for accreditation.

4 Inspection Team

4.1 The inspection team will consist of a minimum of two Board members.

4.2 The members of the inspection team should not be employed by the hospital being inspected.

4.3 The inspection will be organised by the Executive Officer of the Board.

5 Type of Inspection and Process

5.1 Physical

5.1.1 The Board will endeavour to undertake quinquennial inspections physically. New training post inspections will be undertaken physically.

5.1.2 By the application closing date, the Hospital Surgical Supervisor must complete the accreditation application.

5.1.3 Once the application is received the Executive Officer of the Board will create an inspection timetable and send to the Surgical Supervisor so s/he may coordinate the required personnel. The inspection should run for approximately three hours. The schedule will include the following:

a. Interview with Hospital Administration including the Director of Medical (or Surgical) Services
b. Interview with Hospital Head of Unit, Surgical Supervisor and consultants on unit.
c. Interview with Trainees
d. Inspection of operating theatre, endovascular suite, radiology (Interventional), ultrasound lab, outpatient clinic, emergency department, facilities for the trainee
e. Debrief session following conclusion of inspection with hospital administration and Surgical Supervisor.

5.1.4 The Inspection Team will be provided with the following information from the Board Executive Officer:

a. Inspection timetable

b. Hospital Accreditation Application including supporting documentation
c. If the inspection has been prompted due to concerns raised, the inspection team will be provided with that information.
d. Logbooks for the two years preceding the inspection (current post).
e. Logbook data for any unaccredited trainees/registrars who have worked in the post (new post).
f. De-identified trainee feedback reports for the two years preceding the inspection.

5.1.5 Following the inspection, the inspection team will submit a report including accreditation determination to the Surgical Supervisor and hospital administration for review and comment.

5.1.6 Following receipt of the report, the Surgical Supervisor and hospital administration will have 10 working days to provide comment. If no comment is received the report will be considered final and go to the Board for approval.

5.1.7 If the Surgical Supervisor or hospital administration request changes, these will be reviewed by the inspection team and a response will be provided to the hospital within 10 working days. Following final acceptance of the changes, the report will go to the Board for approval.

5.2 Paper-based

5.2.1 In some instances, the Board may determine a physical inspection is not required. The hospital will still be required to submit an accreditation application.

5.2.2 By the application closing date, the Hospital Surgical Supervisor must complete the accreditation application.

5.2.3 In addition to a review of the accreditation application, the Board may request a teleconference with:

a. The Surgical Supervisor
b. Director of Medical (or Surgical) Services
c. All Trainees on Unit

The Board may request to contact other Vascular Surgery consultants or hospital employees if appropriate.

5.2.4 The inspection team will be provided with the following information from the Board Executive Officer:

a. Hospital Accreditation Application
b. Logbooks for the two years preceding the inspection
c. De-identified trainee feedback reports for the two years preceding the inspection

5.2.5 Following review of the application, the inspection team will submit a report including accreditation determination to the Surgical Supervisor and hospital administration for review and comment.

5.2.6 Following receipt of the report, the Surgical Supervisor and hospital administration will have 10 working days to provide comment. If no comment is received the report will be considered final and go the Board for approval.

5.2.7 If the Surgical Supervisor or hospital administration requests changes, these will be reviewed by the inspection team and a response will be provided to the hospital within 10 working days. Following final acceptance of the changes, the report will go to the full Board for approval.

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5.3 Logbook Review

5.3.1 Where deficiency is identified in trainee logbooks the Board may carry out a Logbook Review of the training post prior to the next scheduled quinquennial inspection.

5.3.2 The Logbook review will be undertaken by one Board member who will make a recommendation for approval of the Board.

5.3.3 The member conducting the logbook review should not be employed by the hospital being reviewed.

5.3.4 The hospital may not be required to submit a full accreditation application for a Logbook Review.

5.3.5 A Logbook review will be organised by the Executive Officer of the Board.

6 Allocation of Trainees to Accredited Training Posts

6.1 The trainee and surgical supervisor will be notified of placement for the following year by July each year.

6.2 Upon allocations being made, hospitals are notified of which trainees are placed in that hospital for the training year. While posted at a hospital, the trainee becomes an employee of the hospital and must adhere to the hospitals rules and regulations.

It is the trainee's responsibility to contact the relevant hospital supervisor and medical administration department to arrange employment documents and employment start dates.

6.3 The trainee portfolio, which consists of all previous assessment forms, logbooks, and performance management plans will be provided to the supervisor of training each year.

6.4 A post may remain vacant if:

a. There are no suitable trainees
b. The accreditation of a post is being reviewed and the allocation of a trainee may compromise the quality of the review or the training afforded to the trainee
c. A post becomes vacant to late in the year to logistically accommodate an appointment.

7 Handling and Resolution of Complaints

7.1 The Board will review the accreditation of a training post in the event of a complaint of unacceptable behaviour (discrimination, bullying, sexual harassment, etc.) against a member of an accredited unit and this may result in probationary accreditation or withdrawal of accreditation.

7.2 The Board will report all written complaints of unacceptable behaviour to the RACS Complaints Officer.

7.3 The Board will inform the relevant unit and hospital of the complaint and provide an opportunity to respond.

7.4 The Board will conduct a site visit and carry out the Board's normal accreditation process. During the site visit the hospital will be required to demonstrate that there are policies and procedures in place to assess and respond to complaints. A timeline for reporting and complaint resolution will be established.

7.5 The Board may make return site visits at intervals as required in order to verify that the hospital processes have taken place and reached a satisfactory conclusion.

7.6 The Board may apply probationary accreditation while the complaint is being investigated.

7.7 In respect for individuals' privacy the Board only requires that achievement of an outcome is reported, not specific detail, unless directly relevant to accreditation conditions.

7.8 In the event the hospital fails to complete the process and reach a resolution within the agreed timeline, the Board may

A. apply probationary accreditation.
B. May not allocate trainees until corrective action has been implemented successfully.
C. Withdraw accreditation.

7.9 In response to a complaint the Board may impose additional accreditation conditions of a unit such as attending the face to face OWR Course. Where the unit does not comply with the mandated training accreditation requirements, the post will be withdrawn but may be reinstated when compliance is achieved.

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