

THE ROYAL AUSTRALIAN AND  
NEW ZEALAND COLLEGE OF  
OBSTETRICIANS AND GYNAECOLOGISTS



**RE-ACCREDITATION OF HOSPITALS IN THE  
RANZCOG INTEGRATED TRAINING PROGRAM:  
STANDARDS AND PROCEDURES**

**NOVEMBER 2006**

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The Royal Australian and New Zealand  
College of Obstetricians and Gynaecologists

RE-ACCREDITATION OF HOSPITALS IN THE RANZCOG  
INTEGRATED TRAINING PROGRAM: STANDARDS AND  
PROCEDURES

NOVEMBER 2006



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# SUMMARY OF RE-ACCREDITATION STANDARDS AND OBJECTIVES

## NOTE RE "HOSPITAL" RESPONSIBILITIES

The College appreciates that given the different organisational structures in hospitals, responsibility for implementation of these standards may vary from hospital to hospital and will invariably result in individual or shared action on the part of the hospital administration and the departments or divisions within a hospital responsible for obstetric and gynaecological care.

Reference in the document to "hospitals" should be read as acknowledgement of that shared responsibility.

### **Objectives**

The objectives of accreditation of RANZCOG Training sites are:

- To ensure that the core requirements for clinical and educational experience as defined in the RANZCOG curriculum are being met for all trainees in participating hospitals in each ITP.
- To assist the hospitals in their role as training providers – not just service providers – by identifying factors that are adversely affecting their capacity to deliver effective and supported training to RANZCOG trainees.
- To work with the hospital – and with the relevant local RANZCOG Training and Accreditation Committee – to formulate strategies which will maximise training opportunities and ensure efficient and safe service delivery provision by RANZCOG trainees.

### **Standards**

1. Hospitals are expected to provide support for RANZCOG appointed Training Supervisors at each training site to enable them to provide effective supervision for trainees.
2. Hospitals are expected to provide support for RANZCOG appointed ITP Co-ordinators at each principal ITP hospital.
3. Training sites will ensure that there is adequate senior medical staff to provide effective training, support and supervision of trainees. Tertiary hospitals are expected to have some full-time senior staff. This is essential to ensure safety and quality of clinical services.
4. Hospitals are expected to ensure that there are teaching, training and audit sessions for trainees and to implement strategies to ensure that trainees are able to attend hospital teaching, training and review sessions.
5. Hospitals shall support trainees to undertake their compulsory research project. Major teaching hospitals with a substantial range of academic activities are expected by the College to provide trainees with access to research opportunities with appropriate guidance, mentoring and supervision.
6. Each hospital in the ITP shall effectively contribute, over the four years of the program, to providing registrars with the appropriate clinical experience to meet the core requirements of the RANZCOG curriculum and ensure appropriate levels of clinical competence.
7. Each hospital will employ an adequate number of registrars and residents to ensure the workload for junior medical staff is reasonable such that there are adequate opportunities for training, and award conditions are complied with.
8. Hospitals shall ensure that the structured educational program is supplemented by an adequate range of educational resources as part of the hospital's obligation to provide a supportive learning environment.
9. Accredited rural sites (defined as a site more than 50km from the home/base hospital in the relevant ITP) shall provide support, training and supervision to trainees on rotation to ensure they are able to perform effectively and are appropriately trained.



## PART 1:

# BACKGROUND – RANZCOG, THE CURRICULUM AND THE INTEGRATED TRAINING PROGRAM

## 1. THE ROLE OF THE RANZCOG

### Vision

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists will pursue excellence in the delivery of health care to women throughout their lives.

### Mission

The College will achieve its vision by innovative training, accreditation and continuing education programs, supported by active assessment of the effectiveness of these programs.

The College will actively support and communicate with Fellows and trainees to ensure that they are capable – physically, psychologically and professionally – of providing the highest standards of care.

The College will support research into women's health and will act as an advocate for women's health care by forging productive relationships with individuals, the community, and local and international professional organisations.

### History of the College

The Australian College of Obstetricians and Gynaecologists was formally established in 1978.

This body replaced the former Australian Regional Council, which had been governed by the Royal College of Obstetricians and Gynaecologists (RCOG) in the United Kingdom.

The prefix "Royal" was acquired in 1980 when it became the Royal Australian College of Obstetricians and Gynaecologists (RACOG).

In 1983, the RACOG moved to its current headquarters at 254 Albert Street, East Melbourne, Victoria.

In October 1998, the Royal Australian College of Obstetricians and Gynaecologists amalgamated with the Royal New Zealand College of Obstetricians and Gynaecologists to form the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

## 2. THE RANZCOG CURRICULUM

The curriculum developed by the College for the 6-year Membership/Fellowship training program (of which the RANZCOG accredited hospitals form a crucial part) is a framework of attributes and competencies designed to guide and support the training of specialists in obstetrics and gynaecology. The full details of the curriculum are provided in the booklet which accompanies these re-accreditation guidelines, *The RANZCOG Curriculum: A Framework to Guide the Training and Practice of Specialist Obstetricians and Gynaecologists*. This booklet is an essential tool for understanding the educational basis and structure of the training program. Staff at accredited hospitals who are involved in the training of RANZCOG trainees are expected to be familiar with this document.

## PART 1:

# BACKGROUND – RANZCOG, THE CURRICULUM AND THE INTEGRATED TRAINING PROGRAM (Cont.)

### Objective

The core objective of the curriculum is to equip future specialists with the knowledge, skills and professional qualities appropriate to the healthcare needs of women in two countries, which comprise a diversity of cultures and indigenous populations.

The curriculum is also a response to the challenges of functioning in a healthcare system that is in a constant state of flux and facing increasing financial constraints. Furthermore, it is acknowledged that the professional nature of women's healthcare is undergoing change through advances in technology, an increased emphasis on medical management rather than surgical options, and the demand for healthcare that involves an informed partnership between specialists and the women in their care.

### Specialist practice

The curriculum seeks to describe the essential qualities of a specialist obstetrician and gynaecologist who is equipped to practise effectively in this changing healthcare environment. These characteristics are as follows:

- **clinical expertise** combining medical experience and effective communication;
- **academic abilities** comprising self-learning and research abilities and the capacity to teach;
- **professional qualities** encapsulating responsibilities, practice review and development, team work, ethical attitudes and conduct, a commitment to what is best for the patient, and health advocacy.

The deliberate amalgamation of medical and communication abilities reflects the strongly held position of the College that clinical expertise is dependent on well-developed abilities in both medicine and communication. Similarly, academic abilities and professional qualities are considered to be essential factors in the acquisition of clinical competency in the specialty.

## 3. THE INTEGRATED TRAINING PROGRAM AND THE ROLE OF ACCREDITED HOSPITALS

### The Integrated Training Program – essential components

The RANZCOG training program is a 72-month structured post-graduate program which leads first to certification as a Member (MRANZCOG) of the College and then to certification as a Fellow of the College (FRANZCOG).

The MRANZCOG/FRANZCOG training program includes:

- a four-year Integrated Training Program (ITP), culminating in Membership of the RANZCOG; and
- a two-year Elective Program (EP) culminating in Fellowship of the RANZCOG.

The essential components of the ITP are set to ensure that all trainees registered in the program have access to knowledge, experiences and learning environments necessary for satisfactory assessment of requirements.

## PART 1:

### BACKGROUND – RANZCOG, THE CURRICULUM AND THE INTEGRATED TRAINING PROGRAM (Cont.)

The ITP trainee requirements are as follows:

1. Four years of logged clinical work in obstetrics and gynaecology resulting in attainment of prescribed competency levels in specified procedures (see Part 4, Standard 6, Item 6.1 in these guidelines).
2. Rotation through a minimum of two different hospitals over the four years of training, with at least 12 months in a tertiary hospital and no less than six months in any one hospital
3. Minimum of six months in a rural hospital.
4. Three-month term in gynaecological oncology sufficient to gain a working knowledge of the anatomy of the pelvic sidewall, particularly in regards to the ureter and major blood vessels.
5. Formal three- and six-monthly assessments of the trainee's progress through the ITP.
6. Satisfactory participation in a Basic Surgical Skills Workshop during the first year of training.
7. Satisfactory participation in neonatal resuscitation training in the first year of training.
8. Satisfactory participation in a Communication Skills Workshop by the end of the second year of training.
9. Satisfactory performance in the two In-hospital Clinical Assessments (ultrasound and colposcopy).
10. Satisfactory assessment of competency in specified basic O&G surgical procedures by the end of Year 2 of training.
11. Utilising the resources of the web-based Flexible Learning Program.
12. Passing the MRANZCOG Written Examination.
13. Passing the MRANZCOG Oral Examination.

#### The role of accredited hospitals in the ITP

The Integrated Training Program is based in major teaching hospitals, outer suburban and rural/provincial hospitals accredited for such training by the College. A combination of these different types of hospitals forms a consortium, each known as an Integrated Training Program, although the term is also used generically to refer to the entire four-year program in Australia and New Zealand. An ITP would normally comprise at least two sites and could be offered by:

- A tertiary hospital and a number of peripheral/rural hospitals;
- Two or more tertiary hospitals;
- All of the teaching hospitals within a state or region;
- Three or more hospitals, at least one of which is a tertiary hospital, in different states or regions;
- Three or more hospitals, at least one of which is a tertiary hospital, in different countries.

It is expected that most programs are hospital-based in the sense that trainees receive most of their training at a single home or base hospital and rotate to other hospitals in that ITP. Collectively the participating hospitals must be able to provide over the four years of the program the range of core O&G experiences stipulated in these guidelines.

The following ITPs have been established – and subsequently reviewed - by the College:

- Victoria and Tasmania – 1996;
- South Australia and the Northern Territory – 1996;
- Western Australia – 1996;
- New South Wales and the ACT – 1997;
- Queensland – 1997;
- New Zealand – end of 1997.

## **PART 1:**

### **BACKGROUND – RANZCOG, THE CURRICULUM AND THE INTEGRATED TRAINING PROGRAM (Cont.)**

The overseeing of the ITPs – and the Elective Program – in each state/region is the responsibility of Regional/New Zealand Training and Accreditation (T&A) Committees, which in turn are responsible to the College Training and Accreditation Committee and ultimately to the RANZCOG Council.

As the sites for the first crucial four years of training in obstetrics and gynaecology, the role and responsibilities of accredited ITP hospitals cannot be overestimated. The RANZCOG curriculum emphasises that competency is achieved through an incremental process of learning and development in the key areas of clinical expertise, academic abilities and professional qualities. The Program Co-ordinators, Training Supervisors, consultants, midwifery staff and other health professionals involved in the training of RANZCOG trainees – and the hospital environment in which they work – are crucial to this process in guiding day-to-day learning and ensuring robust growth of the profession. The standards detailed in the present document specify precisely what each hospital must provide as part of its obligations as a RANZCOG-accredited training site.

## PART 2:

# QUALITY ASSURANCE - THE RATIONALE FOR RANZCOG HOSPITAL RE-ACCREDITATION

### 1. BACKGROUND

Since the inception of the first ITPs in 1996, the College has been committed to an ongoing process of evaluation of the quality of training and supervision in accredited hospitals and an identification of factors within hospitals and within ITPs which limit training effectiveness. Reviews have been conducted in each ITP every four years from the date when the ITP was established, with follow-up reviews every two years to assess how effectively the recommendations arising from the main four-yearly review have been implemented.

These ITP reviews - which take the form of on-site confidential interviews on all aspects of training with trainees, Training Supervisors, heads of O&G, senior midwifery staff and hospital management - are conducted by teams from the College comprising an interstate Fellow, a senior staff member and an interstate trainee representative. Each review team is responsible for writing a detailed report on the relevant review, which includes discussion of areas of concern at each training site or within each ITP and recommendations as to how these concerns can be addressed.

The College deliberately delayed the re-accreditation of all ITP sites until each ITP has undergone a four-yearly review at least twice or, in the case of the New Zealand ITPs, one initial four-yearly review and a follow-up review.

### 2. OBJECTIVES OF RANZCOG HOSPITAL RE-ACCREDITATION

The quality assurance issues which were the focus of ITP reviews are also central to the more formal process of re-accreditation of ITP training sites. This process is based on the following key objectives:

1. To ensure that the core requirements for clinical and educational experience as defined in the RANZCOG curriculum are being met for all trainees in participating hospitals in each ITP.
2. To assist the hospitals in their role as training providers - not just service providers - by identifying factors that are adversely affecting their capacity to deliver effective and supported training to RANZCOG trainees.
3. To work with the hospital - and with the relevant local Training and Accreditation Committee - to formulate strategies which will maximise training opportunities and ensure efficient and safe service delivery provision by RANZCOG trainees.

## PART 2:

# QUALITY ASSURANCE - THE RATIONALE FOR RANZCOG HOSPITAL RE-ACCREDITATION (cont.)

### 3. THE RANZCOG PHILOSOPHY OF TRAINING

The College's program of education and training functions within the hospital setting. While recognizing the inevitable conflict between service delivery and training needs, the College emphasises that the training and supervision of trainees must be integrated into the hospital context and service requirements, rather than being seen as secondary to service needs after fulfilling service needs. Trainees have a fundamental requirement: systematic and effective teaching and supervision within a culture and environment that supports them and develops competencies and attributes essential for specialists.

Focusing on quality education and training as a first priority in planning hospital programs and rosters will improve the quality of service for accredited hospitals. Designing rosters that focus on teaching trainees clinical management and procedural skills, and which ensure they receive close and hands-on supervision, is an investment in trainee education which is in the hospital's own best interests. The benefit for the hospitals is the resulting high level service delivery and clinical efficiency in both the short and long term.

## PART 3:

# THE PRINCIPLES AND PROCESSES OF HOSPITAL RE-ACCREDITATION

## 1. PRINCIPLES

The RANZCOG will:

1. Make balanced and objective assessments of each accredited ITP hospital's performance as a training site in accordance with curriculum requirements and the RANZCOG philosophy of training. In doing this, the College will gather and analyse a range of information and viewpoints at each site, including feedback from Fellows of the RANZCOG, trainees, consultants, senior midwifery staff, other health professionals, and hospital/area health service management.
2. Base the accreditation process on clearly defined criteria and implement it in an open and equitable manner.
3. Have an ongoing process of review to ensure that recommended changes are implemented at hospitals and ensure hospitals are given adequate opportunity and support to enable them to implement recommendations effectively.
4. Regularly review the standards and processes of hospital re-accreditation.
5. Ensure that all review teams, relevant committees and College staff involved in the re-accreditation process act in accordance with the above principles and are appropriately trained for their role in the process.

## 2. PROCESSES

### CO-ORDINATION

The implementation and co-ordination of the re-accreditation process will be the responsibility of the College under the direction of the Chair of the College Training and Accreditation Committee (or his/her nominee) and the CEO.

### ORGANISATION (INCLUDING SELECTION OF HOSPITALS TO BE VISITED)

Currently in the RANZCOG training program there are 32 ITPs spread across the Australian states and territories and New Zealand as follows:

- Victoria – 3 ITPs;
- New South Wales & ACT – 9 ITPs;
- South Australia/Northern Territory – 1 ITP;
- Queensland – 18 ITPs;
- Western Australia – 1 ITP;
- Tasmania – 1 ITP;
- New Zealand – 3 ITPs.

These ITPs comprise a total of 88 training sites as follows:

- 28 home/base hospitals (note: some of these are home/base hospital in more than one ITP);
- 32 outer metropolitan sites;
- 28 rural sites.

Hospital re-accreditation will start in early 2007 and the initial cycle is scheduled to be completed within three years.

## PART 3:

# THE PRINCIPLES AND PROCESSES OF HOSPITAL RE-ACCREDITATION (Cont.)

In the initial re-accreditation cycle all 28 home/base hospitals will be visited, as well as 30 of the outer metropolitan and rural sites; a total of 58 sites in all. It is intended that any outer metropolitan and rural hospital not actually visited in the first re-accreditation cycle will still undergo a paper-based review, and will be visited in the next re-accreditation cycle. However, the home/base hospital in each ITP will be visited in each cycle. The specific outer metropolitan and/or rural sites to be visited in each ITP will be decided in consultation with the relevant Regional/New Zealand T&A Committees. Those sites which have been identified in past ITP reviews as experiencing significant problems in terms of effective training provision will be the most likely to be selected for site visits.

### RE-ACCREDITATION PROCESS STEP BY STEP

The re-accreditation process will involve the following steps:

- 1. *Distribution of guidelines:*** Circulation of the re-accreditation guidelines and accompanying RANZCOG curriculum, to all accredited sites and to all RANZCOG Training and Accreditation and Regional Committees several months in advance of the re-accreditation process. The guidelines will include full details on the process, including how site visits will be conducted.
- 2. *Selection of re-accreditation teams:*** Selection and training of the re-accreditation teams responsible for the re-accreditation visits to each site. There will be several teams involved in the whole re-accreditation process. Each team will comprise:
  - a Fellow of the RANZCOG from a state other than the one in which the review is being conducted;
  - a senior member of the RANZCOG Training and Assessment staff;
  - a RANZCOG trainee representative (at least Year 3-4 level) from a state/region other than the one in which the review is being conducted. These trainees' representatives will include all available members of the RANZCOG Trainees' Subcommittee and other appropriate trainees recommended by local Training and Accreditation Committee Chairs, Program Co-ordinators and Trainees' Subcommittee members.
  - Jurisdictions will be invited to participate in the accreditation process.

All team members will be fully trained in all aspects of the re-accreditation process, including its principles, standards and objectives. At least one member of each team will have had previous experience conducting ITP reviews for the College.

- 3. *Notification of site visit:*** Each hospital selected for a site visit and the relevant Regional/New Zealand Training and Accreditation Committee will be given a minimum of two months notice prior to the intended date of the commencement of the re-accreditation. For each hospital this will involve contacting the Chief Executive Officer and Chief Medical Officer (or equivalent), as well as the Head of the O&G Department.
- 4. *Payment of site visit fee by hospital.*** Each home/base hospital in an ITP will be charged a site visit fee of \$3,000 by the College. All other sites will be charged a fee of \$1,000. These fees will contribute to the basic costs of the re-accreditation process. These fees are comparable with those charged by such accrediting bodies as the Australian Council on Healthcare Standards (ACHS) and the Joint Accreditation System of Australia and New Zealand (JAS-ANZ). Hospitals will be invoiced for this fee once the date of the site visit has been finalised. The fees will be reviewed periodically and hospitals advised of any possible fee changes.

## PART 3:

### THE PRINCIPLES AND PROCESSES OF HOSPITAL RE-ACCREDITATION (Cont.)

5. **Obtaining background information from the hospital:** Two months prior to the site visit a standard questionnaire will be sent to the Head of O&G or his/her nominee requiring information on the current number of registrars, the names of the O&G consultants attached to the hospital, the number of deliveries, theatre lists, clinics, rosters and the educational program available to registrars.
6. **Obtaining information from trainees:** At the same time, a standard feedback questionnaire will be sent to all trainees attached to each site requiring information on all aspects of the training program, including supervision, clinical experience, working hours, research opportunities, formal educational programs, teaching opportunities and library/IT facilities.
7. **Analysis of background information by re-accreditation team:** Two weeks prior to the visit the selected review team will meet by teleconference to discuss the documentation provided through the above questionnaires and also information about the site obtained through past ITP reviews conducted by the College. The team will then determine areas of concern which need to be focused on during the visit.
8. **How site visits will be conducted:** Re-accreditation site visits will be of one half day's or one full day's duration (depending on the size of the hospital) and will comprise most, but not necessarily all, of the following:
  - confidential interviews with selected groups of trainees (from various year levels, including senior registrars if available), ITP Co-ordinators and Training Supervisors, Heads of O&G, consultants, senior midwifery staff and hospital management;
  - tour of O&G department;
  - attendance at a formal birthing suite handover;
  - visit to the birthing suite after hours (including talking with midwifery staff on duty);
  - observation of at least one trainee at an antenatal clinic and/or at a gynaecology clinic (including talking with the nursing staff on duty);
  - observation of at least one trainee in theatre;
  - visit to the library and the registrars' room;
  - visit to accommodation provided for registrars (in the case of rural hospitals); and
  - other areas as suggested by the hospital.

The program for the site visit will be organised by the Head of the Department of O&G (or his/her nominee) in consultation with hospital management, where appropriate, and will then be submitted to the College for approval.

9. **Initial feedback provided to hospital:** At the conclusion of the site visit the re-accreditation team will meet to discuss their initial findings. The team will then meet with senior O&G staff and hospital management to discuss those findings and identify issues to be included in the final report on the hospital. As part of the continual improvement process, the hospital will be given the opportunity to comment on the performance of the review team. The team leader will also give senior staff, trainees and hospital management a feedback questionnaire to be

## PART 3:

# THE PRINCIPLES AND PROCESSES OF HOSPITAL RE-ACCREDITATION (Cont.)

returned to the College within two weeks of the visit.

- 10. Drafting the report:** Following the site visit, the review team will draft a report on the visit, including details of any concerns and the grounds on which those concerns are based. The report will be drafted in consultation with the Chair of the College Training and Accreditation Committee, the Chair of the relevant Regional/New Zealand Training and Accreditation Committee, and the CEO of RANZCOG.

Each report will identify the following:

- the strengths and weaknesses of the training provided;
- areas for improvement which need to be addressed;
- recommendations for improvements; and
- the RANZCOG re-accreditation rating for that site based on the report's findings.

- 11. Re-accreditation ratings and consequences of unsatisfactory progress:**

**THE BASIS OF THE RE-ACCREDITATION PROCESS IS FLEXIBILITY AND NEGOTIATION. The aim of the re-accreditation process is to encourage further improvement and development at each training site, not to be punitive. The College will work with each site to make any improvements considered necessary, including negotiating with the hospital to determine which recommendations are realistically achievable in a given time frame or are at least partially achievable. Where necessary, the College will also support the hospital in negotiations with relevant health jurisdictions. Withdrawal of accreditation is regarded as a last resort where a hospital consistently fails to work in partnership with the College to implement its recommendations and provide a safe, supportive and educational training environment.**

The report will indicate the re-accreditation decision applicable to the site:

- 11.1 Full accreditation for a period of 4 years.
- 11.2 Provisional accreditation for a period of 4 years, subject to the implementation of specific recommendations within a stipulated period (usually 12- 24 months). A follow-up review will be conducted at the end of the stipulated period to ensure the recommendations have been implemented or to work with the hospital to devise an effective strategy for working towards implementing those recommendations.
- 11.3 Accreditation for shorter periods of time – 1 year or 2 years – where significant deficiencies have been identified at the site. The College will support the hospital to implement the report's recommendations. Follow-up reviews will be conducted to ascertain the extent to which efforts have been made to implement the report's recommendations.
- 11.4 If the recommendations have not been met within the stipulated timeframe or the hospital is unable to show evidence of genuine progress towards implementing them with the advice and support of the College, the College may:
- a) review the re-accreditation status and impose further conditions accompanied by a revised timeframe within which the recommendations need to be met

## PART 3:

### THE PRINCIPLES AND PROCESSES OF HOSPITAL RE-ACCREDITATION (Cont.)

and a warning to the site that failure to meet this requirement or at least work seriously towards implementing the recommendations will result in loss of accreditation;

- b) withdraw accreditation from the hospital and work with the relevant Regional/New Zealand Training and Accreditation Committee to arrange for the trainees involved to complete their training at other sites. This would only occur in situations when all attempts to bring about improvements with the hospital had failed.

11.5 Re-accreditation of any kind may be refused where the College considers that deficiencies in the training and support provided to trainees at a particular site are serious enough to warrant such action, and where the hospital has not demonstrated any willingness to work towards the implementation of College recommendations.

**12. Report is sent to the hospital:** The final report, containing the appropriate re-accreditation rating, will be sent to the hospital, which will be invited to comment on its accuracy and the appropriateness of the recommendations within one month. Where appropriate, the report may be reviewed by the original review team in consultation with the Chair of the College Training and Accreditation Committee, the CEO, the Chair of the relevant Regional/New Zealand Training and Accreditation Committee and, where appropriate, members of the Executive Committee. If such a review is not considered appropriate or necessary, the hospital and the relevant Regional/New Zealand Training and Accreditation Committee will be informed that the report and its accreditation rating will stand.

**13. Follow-up reviews:** Where a re-accreditation rating is conditional on the hospital implementing specified recommendations within a stipulated timeframe, or at least working towards implementation of them, a follow-up review visit or visits will be conducted by the College to determine to what extent the recommendations have been met. These visits will usually be within 12-18 months of the original site visit. These follow-up reviews will be conducted by a smaller team comprising one Fellow of the College and one member of the College Training and Assessment staff. At least one member of the follow-up review team will be a member of the original re-accreditation team. The follow-up review visit will comprise some but not necessarily all of the features of the original site visit (see item 8 above) and will be followed by a formal report on the team's findings. The report will also indicate whether the hospital has met the conditions of its original re-accreditation rating and, in the event that conditions have not been met, make recommendations as to whether an extension of time is needed or whether the recommendations should be revised to take account of the hospital's particular circumstances and difficulties. The follow-up reviews will include discussion between hospital representatives and the review team as to how the College can support and advise the hospital in implementing the recommendations or at least making substantial progress towards implementing them.

**14. Decisions on withdrawal of accreditation:** In view of the seriousness of withdrawing accreditation from a training site, the final decision on taking such action will be made by the President, the CEO and the Chair of the College Training and Accreditation Committee in close consultation with the relevant review team and the relevant Regional/New Zealand Training and Accreditation Committee.

## PART 4:

# STANDARDS FOR HOSPITAL RE-ACCREDITATION

### RATIONALE, INTERPRETATION AND APPLICATION

The following standards identify what the College regards as the criteria for effective training and support for O&G registrars in their first four years of training. The standards allow for variations in level (e.g. Level 3 nursery versus Levels 1 and 2), and location and function (e.g. major metropolitan teaching hospital versus a rural site). The standards are, however, broadly applicable to all sites. They are derived from RANZCOG's experience with the hospital reviews conducted in every ITP in Australia and New Zealand between 1999 and 2005 and are seen by the College as realistic and achievable.

### STANDARDS AND THE RESPONSIBILITY OF HOSPITALS AND HEALTH JURISDICTIONS

In this document, the College has set out its considered advice or position on the standards required to provide education and training that meets appropriate benchmarks of quality, safety and competence.

The College acknowledges, however, that the terms and conditions of employment or engagement of trainees, training supervisors, coordinators and consultants are ultimately a matter for hospitals and/or health jurisdictions to determine in consultation or negotiation with staff or consultants.

### HIGH PRIORITY STANDARDS

The College also recognises that due to budget and staffing constraints and other considerations some hospitals may have difficulty implementing the standards detailed in this document. To assist hospital managements and health jurisdictions, those elements of the standards which the College regards as high priority are highlighted in red.

These standards relate to supervision and support of trainees by consultants, protected teaching time, adequate consultant staffing to support and train the trainees, and maximum registrar working hours. The standards apply equally to the training of senior trainees in the College's Elective Program (i.e. Years 5 and 6), even though they do not occupy formally accredited hospital positions.

**These high priority standards are included as a guide. If a hospital is unable to meet one or several of the standards, it does not mean it will lose accreditation. As long as the hospital makes every reasonable effort to work collaboratively with the College to facilitate these standards over time, conditional accreditation will be maintained.**

### THE ORDER IN WHICH STANDARDS ARE LISTED

The order in which the standards appear in these guidelines reflects College priorities, particularly its view that strong supervision and support of trainees by both RANZCOG Training Supervisors and VMOs, together with a structured and protected in-hospital educational program, are essential prerequisites for a successful training site. If these prerequisites are in place – creating a positive training culture – then, over the four years of rotations, trainees should be effectively trained in, and appropriately rostered for, the core clinical experiences defined by the RANZCOG curriculum. Hence, the standards relating to the roles of the Training Supervisors, ITP Co-ordinators and consultants are listed first, followed by standards dealing with educational programs and research opportunities, and concluding with those standards relating to the provision of core levels of clinical experience, as well as appropriate staffing and rostering.

**APPLICABILITY OF STANDARDS (AUSTRALIA AND NEW ZEALAND)**

While acknowledging that there are some differences in the training situations prevailing in Australia and New Zealand the RANZCOG training program and the College's expectations of any accredited site are the same for both countries. Consequently, these standards should be seen as equally applicable in Australia and New Zealand.

**FAMILIARISATION WITH STANDARDS**

Hospital management and relevant health jurisdictions are strongly urged to make themselves familiar with these standards, particularly those relating to the importance of appropriate supervision and support of the trainee by the RANZCOG appointed Training Supervisor and by the O&G consultants attached to the hospital with whom the trainees work.

The standards detailed in this document are not intended to be punitive but rather have been compiled as a comprehensive guide to assist and support hospitals in the provision of effective training.

## STANDARD 1:

### APPOINTMENT AND SUPPORT OF TRAINING SUPERVISORS

## STANDARD 1: APPOINTMENT AND SUPPORT OF TRAINING SUPERVISORS

Hospitals are expected to provide support for RANZCOG appointed Training Supervisors at each training site to enable them to provide effective supervision for trainees.

#### CRITERIA

#### 1.1 Support for the Training Supervisor by the hospital

1.1.1 **Paid and protected time.** A high priority expectation of the College is the provision of annualised paid and protected supervision/teaching time to each staff member who performs the role of a Training Supervisor to enable him/her to carry out their duties effectively. The College acknowledges that this issue is a matter for individual employers and the applicable awards/contracts, but would regard the stated standard as an objective to be worked towards over time through close collaboration between the employer and the RANZCOG. As an approximate guide this paid/protected time should be calculated on the basis of at least 10 hours annually per trainee supervised. The special responsibilities of the supervisor should be acknowledged in his/her hospital contract and position description, including the provision of this paid and protected time. Payment for this time can be in addition to the supervisor's salary or factored in as part of the contracted salary.

#### 1.1.2 Attendance at a RANZCOG Training Supervisor workshop

One of the College requirements for Training Supervisors is attendance at a 'train the trainers' workshops run by senior College staff. Hospitals are expected to allow Fellows of the College who act as Training Supervisors to participate in one such workshop, either in person or via video link. These workshops will be held on a semi-regular basis and supervisors will be advised of the dates well in advance.

#### Role and responsibilities of the Training Supervisor: effective supervision and training

1.1.3 **Role.** Supervision of trainees within each participating hospital is the responsibility of designated Training Supervisors, who are consultants on the hospital staff. The Training Supervisor is elected by the Fellows with appointments in the relevant hospital and ratified by the relevant College Regional/New Zealand Training and Accreditation Committee.

1.1.4 **Responsibilities.** The responsibilities of the Training Supervisor are as follows:

1.1.4.1 To provide support to trainees and ensure hands-on supervision and training. This supervision must include:

- provision of regular constructive formal and informal feedback;
- ensuring trainees are taken through each new procedure by a consultant or senior registrar and are given adequate opportunities to practise their skills under supervision; this must include close

## STANDARD 1:

### APPOINTMENT AND SUPPORT OF TRAINING SUPERVISORS (Cont.)

observation of practice eg. observing trainees perform a Caesarean section and tracking their post-operative assessment of a case, their intra-operative performance, and their post-operative care; \*

- ensuring ward rounds are treated as vital training opportunities with appropriate consultant and senior registrar involvement;
- ensuring that trainees have appropriate support from on-call consultants after hours;
- encouraging trainees to improve their communication and decision-making skills;
- listening to trainees' concerns about training and respecting their right to be assertive and questioning; and
- treating trainees with respect and courtesy.

1.1.4.2 To set aside dedicated time each week to teach/supervise/mentor trainees. **(Note: This includes time spent giving feedback to trainees or contributing to the planning of the in-hospital O&G educational program, not simply time spent in hands-on teaching.)**

1.1.4.3 To ensure, or make every reasonable effort to ensure, that trainees are rostered on a regular basis so they can access key educational/training opportunities such as registrars' meetings, perinatal mortality/morbidity sessions, ultrasound experience, and any specialised clinics conducted at the hospital.

1.1.4.4 To conduct the compulsory three-monthly formative assessment of each trainee using the **RANZCOG mid-semester report** form. This assessment – based on the supervisor's own observations and feedback from consultants, midwives and other health professionals who have worked with the trainee – must include a confidential face-to-face discussion with the trainee about his/her performance and progress.

1.1.4.5 To conduct the compulsory six-monthly summative assessment of each trainee using the **RANZCOG Six-monthly Report** form. This assessment must be compiled from the **Consultant Assessment of Trainee** form completed by each consultant who worked with the trainee during the six-month period. Copies of these forms should be distributed to the consultants at least 2-3 weeks before the end of the six-month period by the Training Supervisor – not by the trainee. The assessment by the supervisor must include a confidential face-to-face discussion with the trainee about his/her performance and progress.

1.1.4.6 To review and sign each trainee's logbook every three months to ensure that the trainee is completing the required clinical procedures.

1.1.4.7 To check each trainee's completed clinical training summary sheets every six months and sign them off if satisfactory.

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\* This does not mean that all teaching responsibilities should fall to the supervisor, only that the supervisor should ensure hands-on teaching is provided by an appropriate trainer, which could be the supervisor him/herself, another consultant or a senior registrar.

## STANDARD 1:

### APPOINTMENT AND SUPPORT OF TRAINING SUPERVISORS (Cont.)

- 1.1.4.8 To ensure the assessment of the trainee's competence in basic surgical skills at the end of Year 2 using the **RANZCOG Surgical Procedures – Assessment of Trainee Competence** form, or to arrange for an appropriate consultant to conduct such assessments.
  - 1.1.4.9 To organise the **In-hospital Clinical Assessments** of the trainees by selecting an appropriate assessor from the official RANZCOG list of IHCA approved assessors.
  - 1.1.4.10 To be fully apprised of the requirements of the **RANZCOG Curriculum** and the current regulations governing training and assessment by consulting the Curriculum and the **RANZCOG Training Program Handbook**, both of which are available on the College website.
  - 1.1.4.11 To liaise closely with the relevant Program Co-ordinator and/or Regional/ New Zealand Training and Accreditation Committee Chair in order to discuss training issues and problems, particularly where the hospital is having difficulties providing trainees with the clinical experience and support detailed above.
- 1.1.5 **Ratio.** For appropriately supervised and supported training the ratio of Training Supervisors to registrars is as follows:
- 1 supervisor to every 3 trainees;
  - 2 supervisors for every 7 trainees .

## STANDARD 2:

### APPOINTMENT AND SUPPORT OF PROGRAM CO-ORDINATORS

## STANDARD 2: APPOINTMENT AND SUPPORT OF PROGRAM CO-ORDINATORS

Hospitals are expected to provide support for RANZCOG appointed ITP Co-ordinators at each principal ITP hospital.

### CRITERIA

#### 2.1 Support for the Program Co-ordinator by the hospital

- 2.1.1 **Paid and protected time.** A high priority expectation of the College is the provision of one paid and protected session per fortnight to the staff member who performs the role of a Program Co-ordinator (usually based at the home/base hospital in the ITP) to enable him/her to carry out their duties effectively. The College acknowledges that this issue is a matter for individual employers and the applicable awards/contracts, but would regard the stated standard as an objective to be worked towards over time through close collaboration between the employer and the RANZCOG. The special responsibilities of the Program Co-ordinator should be acknowledged in his/her hospital contract and position description, including the provision of this paid and protected time. Payment for this time can be in addition to the supervisor's salary or factored in as part of the contracted salary.

#### **Role and responsibilities of the Program Co-ordinator: effective co-ordination of the ITP**

- 2.1.2 **Role.** Co-ordination of the ITP across participating hospitals is the responsibility of the Program Co-ordinator, who is a consultant on the hospital staff (usually the home/base hospital in the ITP). He or she is elected by the RANZCOG Fellows with appointments in the relevant hospitals and that election is ratified by the relevant College Regional/New Zealand Training and Accreditation Committee.
- 2.1.3 **Responsibilities.** The responsibilities of the Program Co-ordinator include:
- 2.1.3.1 Contribute to the development of a planned program of teaching for trainees within all the hospitals in the relevant consortium, which is consistent with the training objectives determined by the College.
  - 2.1.3.2 Liaise with the relevant persons within the hospitals comprising the consortium, particularly the Training Supervisors, to ensure that the training program is implemented and supported appropriately.
  - 2.1.3.3 Advise Training Supervisors in the performance of their tasks as required.
  - 2.1.3.4 Assist in the counselling of trainees experiencing difficulties in their training and where necessary assisting in the implementation of a remedial plan for such trainees.
  - 2.1.3.5 Assist the relevant Regional/New Zealand Training and Accreditation Committee Chair in the appraisal of Training Supervisors' performance on a regular basis.

## STANDARD 3:

### TRAINING AND SUPPORT FOR TRAINEES BY CONSULTANTS - INCLUDING AFTER HOURS SUPERVISION

#### STANDARD 3: TRAINING AND SUPPORT FOR TRAINEES BY CONSULTANTS - INCLUDING AFTER HOURS SUPERVISION

Training sites will ensure that there is adequate senior medical staff to provide effective training, support and supervision of trainees. Tertiary hospitals are expected to have some full-time senior staff. This is essential to ensure safety and quality of clinical services.

#### CRITERIA

##### 3.1 The role of the hospital: ensuring appropriate consultant support of registrars.

- 3.1.1 **Contracts.** While the College acknowledges that contracts are a matter for the individual employer, it is an expectation of the RANZCOG that the hospital contracts negotiated with each consultant should clearly stipulate that they are required to supervise and teach the trainees they work with, including carrying out the responsibilities listed below. The College sees this as a standard to be worked towards over time through close collaboration between the employer and the RANZCOG.
- 3.1.2 **Appropriate after hours supervision of first-year trainees.** No first-year trainee should be rostered for night duty without adequate supervision by a consultant (either on-site or on-call) or a senior registrar, unless the trainee has been credentialed by the hospital to perform specific procedures without supervision.
- 3.1.3 **Distance from hospital when on-call.** Any consultant on the on-call roster must be available within 30 minutes or, failing that, the contract should stipulate that the consultant must stay overnight when on-call and be provided with appropriate accommodation. This is a safety and quality requirement.
- 3.1.4 **Team structure.** Tertiary level hospitals should implement a planned team/unit structure which ensures that, wherever possible, each trainee is attached to a particular consultant for a period of between three and six months.
- 3.1.5 **Appropriate staffing.** Large teaching hospitals accredited for O&G training must ensure an appropriate number of specialists to provide effective hands-on supervision.
- 3.1.6 **Organising rosters/educational program.** Level 2 and 3 hospitals should have at least one specialist who assumes primary responsibility for the ITP trainees, including organising rosters and the educational program (or overseeing an experienced trainee to whom these functions may be delegated).
- 3.1.7 **Birthing suite.** In a level 3 hospital a full-time consultant should be rostered for the delivery suite between 8 am and 6 pm each day to provide close supervision and support for senior trainees and ITP trainees (particularly first-year trainees).
- 3.1.8 **Full-time consultants (or equivalent).** The number of consultants required at one of the above sites will be determined by the workload and the number of registrars and residents. There should, however, be sufficient consultants to cover the following key areas:

## STANDARD 3:

### TRAINING AND SUPPORT FOR TRAINEES BY CONSULTANTS - INCLUDING AFTER HOURS SUPERVISION (Cont.)

- 24-hour birthing suite supervision (whether on-site or on-call);
- teaching and supervision of trainees in gynaecology;
- regular and active involvement in a structured educational program;
- co-ordination of audit activities in both obstetrics and gynaecology; and
- input into trainee research activities.

#### 3.2 The responsibilities of the consultant: effective supervision and training

- 3.2.1 **Role.** While the Program Co-ordinator and the Training Supervisor have overall responsibility for the training of the registrars at their hospital, the day-to-day responsibility for training and supporting them is actually that of the consultants with whom the trainees work most closely.
- 3.2.2 **Responsibilities.** The College expectations of the consultant are as follows:
- 3.2.2.1 To provide support to trainees and ensure appropriate hands-on supervision and training at all times. This supervision should include:
- regular constructive feedback;
  - ensuring trainees are taken through each new procedure and are given adequate opportunities to practise their skills under supervision (eg Caesarean sections, forceps, ventouse, episiotomy repairs and third degree tears); this should also include close observation of practice, eg observing the trainee perform a Caesarean section and tracking their pre-operative assessment of a case, their intra-operative performance, and their post-operative care;
  - taking trainees through the process of case follow-up and dealing with documentation;
  - being present at birthing suite handovers and gynaecology ward rounds (as appropriate) in recognition that these are vital training opportunities;
  - being readily available and supportive to trainees when on-call after hours and always coming in for designated procedures, where required (see below);
  - assisting trainees to improve their communication and decision-making skills;
  - listening to trainees' concerns about training and respecting their right to be assertive and questioning;
  - acting as a mentor to trainees, including providing emotional support and career advice when appropriate; and
  - treating trainees with respect and courtesy.

## STANDARD 3:

### TRAINING AND SUPPORT FOR TRAINEES BY CONSULTANTS - INCLUDING AFTER HOURS SUPERVISION (Cont.)

- 3.2.2.2 To come in promptly when on-call after hours if requested to do so by a trainee or if the in-house credentialing process indicates that a trainee must have consultant back-up after hours because of their current level of competence and confidence with a specific procedure (see Standard 6, Item 6.3 below).
- 3.2.2.3 To regularly attend and be actively involved in the structured in-hospital education program for trainees, including case presentations and perinatal mortality/morbidity sessions.
- 3.2.2.4 To contribute to the formal assessment of registrars by completing the **RANZCOG Consultant Assessment of Trainee** form, which is used as the basis for the six-monthly summative assessment conducted by each trainee's Training Supervisor. In making this assessment the consultant should be objective and fair, and provide detailed comments to assist the Training Supervisor to accurately gauge the trainee's performance and progress.

## STANDARD 4:

# STRUCTURED EDUCATIONAL PROGRAMS AND LEARNING OPPORTUNITES (INCLUDING TEACHING OPPORTUNITIES)

## STANDARD 4: STRUCTURED EDUCATIONAL PROGRAMS AND LEARNING OPPORTUNITIES (INCLUDING TEACHING OPPORTUNITIES)

Hospitals are expected to ensure that there are teaching, training and audit sessions for trainees and to implement strategies to ensure that trainees are able to attend hospital teaching, training and review sessions.

### CRITERIA

#### 4.1 Provision of structured educational programs

4.1.1 **Educational program components – home/base sites.** Accredited home/base hospitals, with their academic departments and educational resources, are expected to implement the most comprehensive formal educational program in the relevant ITP, covering an extensive range of obstetric and gynaecological topics and other learning opportunities. The program should include the following on a regular basis:

- tutorial/registrars' meeting with the requirement for registrars to give presentations on a rotating basis;
- journal club;
- gynaecology clinic case review;
- perinatal and neonatal morbidity/mortality meeting (conducted in a "no-blame" atmosphere which encourages registrars to contribute to the discussion);
- CTG meeting;
- high-risk obstetric review meeting;
- gynaecology teaching round; and
- intrapartum management tutorial.

4.1.2 **Educational program components – peripheral/rural sites.** Peripheral/rural sites should also have a structured though less comprehensive program. For example:

- regular teaching session;
- combined case review meeting looking at Caesarean sections and any vaginal delivery needing evaluation (where the registrars are required to present a case or audits on Caesarean/instrumental deliveries on a regular basis); and
- perinatal morbidity/mortality meetings (approximately every three months).

## STANDARD 4:

### STRUCTURED EDUCATIONAL PROGRAMS AND LEARNING OPPORTUNITIES (INCLUDING TEACHING OPPORTUNITIES) (Cont.)

- 4.1.3 **Protected teaching time.** It is a high priority expectation of the College that trainees be given protected teaching time in order to attend educational sessions. It is not considered acceptable for registrars to repeatedly miss sessions because they are rostered for birthing suite, clinics or theatre. (Note: By implementing the strategies outlined in Item 4.1.4 below, hospitals should be able to meet this standard without having to increase the staff complement).
- 4.1.4 **Ensuring registrar attendance.** Every effort should be made to ensure trainees attend educational sessions, including arranging for a Consultant or senior registrar to cover the birthing suite or the clinics at these times and hold the trainees' pagers (nurses should be instructed not to call trainees attending educational meetings). If such an arrangement is not possible, then the roster should ensure that trainees take it in turns to cover the birthing suite or clinics without continually missing out on key sessions.
- 4.1.5 **Co-ordination of educational program.** The educational program should be managed by one of the consultants or by a senior registrar or other experienced trainee who is overseen in this role by the consultant. Consultants should be in regular attendance and use the sessions as vital teaching opportunities (including making formal presentations on a regular basis).

#### 4.2 Provision of regular teaching opportunities for trainees where possible

- 4.2.1 **Teaching residents and medical students.** An important part of trainees' professional development is regular teaching of medical students at their hospital. The ultimate way for learners to clarify their own understanding of a subject or a clinical procedure is to teach it to someone else. Where possible, accredited sites involved in the training of residents and/or medical students are encouraged to roster registrars into the tutorial program for residents and/or medical students and arrange for the registrars to give tutorials. Trainees should also be given the opportunity for one-on-one teaching with residents on the ward or in theatre where such an arrangement is feasible and appropriate.

## STANDARD 5:

### RESEARCH OPPORTUNITIES AND PROTECTED RESEARCH/STUDY TIME

#### STANDARD 5: RESEARCH OPPORTUNITIES AND PROTECTED RESEARCH/STUDY TIME

Hospitals shall support trainees to undertake their compulsory research project. Major teaching hospitals with a substantial range of academic activities are expected by the College to provide trainees with access to research opportunities with appropriate guidance, mentoring and supervision.

#### CRITERIA

##### 5.1 Provision of research opportunities and active encouragement of research activity by registrars

5.1.1 **Compulsory research requirement.** The RANZCOG curriculum contains a compulsory research requirement that every trainee must undertake a project consisting of work in some aspect of, or pertaining to, the health sciences. While trainees have six years in which to complete the project, its substantial nature requires that they develop their research proposal and commence work on the project well before the end of Year 3.

5.1.2 **Research opportunities.** The provision of research opportunities should include: Identifying individuals on staff who can provide support, advice and encouragement to trainees to undertake research projects.

1. Allocation of a paid and protected half day of research/study time per fortnight for trainees at the accredited site i.e. where there is no existing state/regional provision of protected study time for trainees. (The College expectation is not in addition to any existing state/regional provisions for study time.
2. Identifying a range of research possibilities for trainees, not just focusing on audit activities and literature reviews, although these can certainly be a stimulus to further investigation of a clinical area by trainees.

5.1.3 **Research opportunities at peripheral/rural sites.** While research activity is not normally a priority at peripheral or rural sites, these sites are expected to encourage trainees' research interests wherever possible; eg by encouraging them to participate in obstetric audits, assist in the review and writing of protocols, etc.

## STANDARD 6:

### PROVISION OF CORE LEVELS OF CLINICAL EXPERIENCE - COMPETENCY AND IN-HOUSE CREDENTIALING ISSUES

#### STANDARD 6: PROVISION OF CORE LEVELS OF CLINICAL EXPERIENCE - COMPETENCY AND IN-HOUSE CREDENTIALING ISSUES

Each hospital in the ITP shall effectively contribute, over the four years of the program, to providing registrars with the appropriate clinical experience to meet the core requirements of the RANZCOG curriculum and ensure appropriate levels of clinical competence.

#### CRITERIA

##### 6.1 Levels of clinical experience and attainment of competency

###### 6.1.1 RANZCOG minimum clinical procedures requirements per trainee.

**IMPORTANT NOTE:**

Based on experience, these clinical procedures figures are intended as a guide to what the College considers the minimum necessary in order for each trainee to achieve basic competency. The figures are cumulative i.e. over the four years of the program as each trainee rotates through several sites. As long as genuine efforts have been made by the participating hospitals to meet these figures, no hospital – or trainee - will be penalised if these targets are not always reached.

Procedure	Requirement
Normal deliveries/labours/in labour decisions	20
Operative deliveries/labours/in labour decisions	100
Caesarean sections	150
Major abdominal	50
Major vaginal	50
Laparoscopies	50
Hysteroscopies	100
Colposcopies	100
Gynaecological clinics	100*
Obstetric clinics	100*
<i>* Denotes number of clinics, not hours</i>	
Gynaecological oncology	3 months' experience but not necessarily in a formally designated gynaecological oncology unit, (eg a hospital where there is no specific gynaecological oncology service on-site but multiple gynaecologists are available).
Ultrasound	Achievement of basic pre-Membership competencies over 18 x 8-hour days (see details below) i.e. 4 weeks or approx. 150 hours.

## STANDARD 6:

### PROVISION OF CORE LEVELS OF CLINICAL EXPERIENCE - COMPETENCY AND IN-HOUSE CREDENTIALING ISSUES (Cont.)

6.1.2 **Competency in core O&G surgical skills.** By the end of Year 2 of the training program trainees are expected to be competent in the following procedures **as the primary operator (under appropriate supervision)**:

#### Gynaecology

- a) **Abdominal procedures**  
laparotomy; simple TAH
- b) **Laparoscopic procedures**  
diagnostic laparoscopy
- c) **Hysteroscopic procedures**  
hysteroscopy D&C

#### Obstetric

- a) **Vaginal/episiotomy**  
vaginal delivery and episiotomy repair
- b) **Instrumental delivery**  
low instrumental delivery: vacuum or forceps
- c) **Caesarean section**  
LUSCS

NOTE: Obstetric training should also include such common obstetric procedures or emergencies as breech management, shoulder dystocia and postpartum haemorrhage.

6.1.3 **Basic competencies in ultrasound.** The competencies listed below are to be acquired through supervised training in the ultrasound department or other appropriate facility in the home/base hospital or a peripheral hospital of the ITP, preferably in Year 1 and certainly by the end of Year 2. As indicated above, to obtain these competencies trainees will require a minimum of 36 x 4-hour sessions (i.e. approximately 150 hours or 4 weeks of clinical training and experience). The College regards anything less than this as inadequate to acquire the essential competencies.

#### Core Knowledge

##### A. Physics

- Understand clinically relevant aspects of the physics of diagnostic ultrasound.
  - 1. Demonstrate knowledge about the physics of diagnostic ultrasound with respect to:
    - a. how ultrasound is propagated in tissue;
    - b. principles of real time ultrasound;
    - c. principles of grey-scale imaging;
    - d. principles of Doppler ultrasound;
    - e. transducer types, properties and functions;
    - f. common artefacts such as shadowing and reverberation and how they occur.
  - 2. Demonstrate awareness of bioeffects and safety of ultrasound.

## STANDARD 6:

### PROVISION OF CORE LEVELS OF CLINICAL EXPERIENCE - COMPETENCY AND IN-HOUSE CREDENTIALING ISSUES (Cont.)

#### B. Biometry

- Understand the principles of determining gestational age in the first, second and third trimesters of pregnancy.
  1. Know how to measure gestation sac, crown rump length, biparietal diameter, head circumference, abdominal circumference and femur length.
  2. Understand the accuracy of measurements at different gestational ages and when it is appropriate to change dates.
  3. Understand the use and limitations of measurement charts.

#### C. First Trimester

- Understand the principles of the diagnosis of early intrauterine pregnancy, miscarriage, ectopic pregnancy and molar pregnancy.
  1. Know the distinguishing appearances of early intrauterine pregnancy, miscarriage, ectopic pregnancy and molar pregnancy.
  2. Understand the limitations in assessment of first trimester pregnancy.
  3. Understand the use of quantitative betaHCG and its role in the diagnosis of normal and abnormal early pregnancy.
- Recognise the common appearances of corpus luteums.

#### D. Third Trimester

- Understand the assessment of growth and wellbeing in the third trimester
  1. Understand the limitations in fetal assessment of growth.
  2. Understand the benefits and limitations of umbilical artery Doppler assessment and amniotic fluid volume assessment.
  3. Understand the assessment of intrauterine growth-restricted (IUGR) fetuses.
- Understand the assessment of placental position.
  1. Know the features of a normally sited placenta.
  2. Understand placental site assessment.

## STANDARD 6:

### PROVISION OF CORE LEVELS OF CLINICAL EXPERIENCE - COMPETENCY AND IN-HOUSE CREDENTIALING ISSUES (Cont.)

- E. Screening for aneuploidy in the first and second trimesters of pregnancy
- Understand the principles of screening for aneuploidy in the first trimester.
    1. Demonstrate awareness of the Fetal Medicine Foundation criteria for nuchal translucency assessment.
    2. Demonstrate knowledge of the value of different combinations used to screen in the first trimester.
    3. Understand the principles of screening for aneuploidy in the second trimester.
    4. Understand maternal serum biochemical screening.
    5. Understand the limitations of ultrasound screening for aneuploidy in the second trimester.
- F. Fetal Abnormality
- Understand the use of ultrasound examination as a screening test for fetal abnormality in the second trimester.
    1. Understand the Cochrane evidence on routine screening.
    2. Understand differing accuracy in diagnosis of abnormality in particular organ systems. (Bricker et al HT &Ass 2000.)
  - Understand the management of an ultrasound-detected fetal abnormality using neural tube defect (NTD) as an example.
- G. Ultrasound Reporting
- Understand the core information required in an ultrasound report for each trimester.
    1. Format a routine first trimester report.
    2. Format a routine second trimester report.
    3. Format a routine third trimester report.

#### **Clinical Skills**

1. Practical aspects of ultrasound scanning
  - a) machine settings;
  - b) probe orientation and manipulation;
  - c) scanning techniques.

## STANDARD 6:

### PROVISION OF CORE LEVELS OF CLINICAL EXPERIENCE - COMPETENCY AND IN-HOUSE CREDENTIALING ISSUES (Cont.)

2. Using TA and TV imaging, make an accurate assessment of:
  - a) uterus and cervix;
  - b) fetal number;
  - c) presence or absence of heart motion after 8 weeks' gestation;
  - d) duration of pregnancy or size of fetus using CRL, BPD, HC, AC and FL;
  - e) presentation;
  - f) site of placentation;
  - g) normal amniotic fluid volume.

Minimum procedural requirements to acquire the above competencies: 25 supervised transvaginal scans and 50 supervised transabdominal scans.

#### 6.2 Access to clinical experience: planning of rotations within an ITP and planning of individual hospital rosters and theatre lists

6.2.1 **Organising rotations, rosters and theatre lists.** The rotations for each trainee in an ITP and the work roster at each participating hospital must be co-ordinated to provide the trainee with maximum exposure to all available O&G clinical areas over the course of the program.

Early advice to the trainee regarding their rotations throughout the four years of the ITP is seen as a high priority expectation, particularly in regard to the timing of the rural rotation.

Clinical responsibilities and training opportunities should increase in complexity as the trainee becomes more senior. Rotations should be arranged to reflect their increasing experience.

#### **Rosters**

Each trainee at a Level 3 hospital must be given rostered access to the available opportunities in:

- obstetrics (both high-risk and low-risk);
- general gynaecological surgery (including operative laparoscopy);
- urogynaecology (at least a 3-month term);
- gynaecological oncology (at least a 3-month term, although not necessarily at a formal gynaecological oncology site);
- colposcopy;
- ultrasound; and
- REI.

As an approximate guide, a roster for a trainee at a Level 3 hospital should include regular sessions of the following over the period of the rotation to ensure overall competency is achieved:

- full day in the birthing suite;
- gynaecological theatre;
- Caesarean section list;
- antenatal clinic;
- gynaecological clinic;
- ward round;
- minor procedures;

## STANDARD 6:

### PROVISION OF CORE LEVELS OF CLINICAL EXPERIENCE - COMPETENCY AND IN-HOUSE CREDENTIALING ISSUES (Cont.)

- ultrasound;
- pre-admission clinic; and
- ongoing experience in organising patients' treatment (from admission through to discharge).

#### Theatre lists

While the allocation of lists depends on the number of registrars at a particular site and their level of experience, over the four years of the program each trainee should achieve sufficient theatre experience as the primary operator to meet the College clinical requirements (or get as close to them as is practicable), in order to gain competency in the required procedures. As a guide, a trainee at a major metropolitan hospital should get at least 1 major list per week, as well as regular experience in minor procedures, while each trainee in a rural setting should have access to 2 – 3 major lists per week and 1 – 2 day surgery lists, depending on the size of the hospital and the available caseload.

NOTE: The College recognises that the training of registrars in theatre is time-consuming and may affect hospital throughput; however the provision of appropriate surgical experience is, nevertheless, an essential requirement of a RANZCOG-accredited site.

- 6.2.2 **Accessing educational/training opportunities.** Rosters must not be designed solely with the objective of service delivery; there must be recognition that it is essential that trainees have regular access to key educational/training opportunities such as ultrasound training, specialised clinics (colposcopy, menopause, fertility, etc.), perinatal mortality/morbidity meetings, registrars' meetings, journal clubs, etc.
- 6.2.3 **Night duty.** Trainees should not be rostered on for protracted periods of night duty where there is less opportunity for training and teaching.
- 6.2.4 **Overseas Fellows.** Trainee access to general gynaecological surgical experience, laparoscopy, urogynaecology and other subspecialist areas should not be limited because overseas Fellows at the hospital are given priority access to these areas.  
NOTE: The College acknowledges that giving such priority access to overseas Fellows is a widespread practice, however if an accredited site made no effort to address this problem it would be viewed with concern and could affect that hospital's re-accreditation rating (eg conditional accreditation subject to implementing specific recommendations relating to this issue).
- 6.2.5 **Accredited vs non-accredited registrars.** Rosters for theatre lists, ultrasound, colposcopy clinics, etc. should differentiate between accredited and non-accredited registrars. While the College acknowledges the important service role of the non-accredited registrars and their training needs, it is expected that the primary obligations is to the RANZCOG accredited registrars. The rostering system and the position descriptions for accredited registrars should reflect this. In New Zealand rosters should also distinguish between the experiences and responsibilities of accredited registrars and overseas trained doctors who are undertaking pre-vocational training.
- 6.2.6 **Importance of primary operator experience.** Trainee experience as the primary operator when in theatre should be maximised, although this will be at the consultant's discretion based on an accurate assessment of the trainees' abilities and their year level. A situation where on a regular basis particular consultants do virtually all the operating and leave the registrar to assist or simply observe is not appropriate training.

## STANDARD 6:

### PROVISION OF CORE LEVELS OF CLINICAL EXPERIENCE - COMPETENCY AND IN-HOUSE CREDENTIALING ISSUES (Cont.)

- 6.2.7 **Responsibility for rostering.** Rostering arrangements must not be left to hospital staff unaware of the specific training needs of O&G trainees. It is expected that the RANZCOG Training Supervisor/s at the hospital, consultants and senior registrars will have strong input into the rostering process.
- 6.2.8 **Birthing suite rostering.** First-year trainees must always be rostered on with either a senior trainee or a consultant who is dedicated to the birthing suite, except where the in-house credentialing process has identified a trainee as proficient enough not to require such supervision.
- 6.2.9 **Covering delivery ward & Accident/Emergency.** No roster at an accredited tertiary hospital should require an after hours registrar to cover both the delivery ward *and* Accident and Emergency on their own as a matter of course. In such a clinically difficult – and litigious - area as maternity care it is not considered acceptable to have a single registrar trying to cover so many areas without the support of a second registrar or a hospital medical officer who can adequately support the registrar (see also 6.2.10 overleaf).

NOTE: In smaller hospitals where nights may be less onerous, it may be appropriate to have the night registrar also see cases in gynaecology triage.

- 6.2.10 **After hours support by appropriate hospital medical officers.** Hospital rosters must ensure that after hours support for registrars on the birthing suite by hospital medical officers is sufficient to enable them to perform their service responsibilities effectively and safely. The officers should be available to perform the following functions:

- insert cannulas;
- perform vaginal examinations;
- conduct initial assessments;
- perform episiotomy repairs;
- cover emergency;
- handle drug orders/prescriptions; and
- clerking in and out.

In a Level 3 hospital, where there is a heavy workload in the birthing suite after hours and the registrar may be expected to cover emergency, antenatal/gynaecology ward and postnatal ward as well, the provision of appropriate 24-hour cover by appropriate hospital medical officers is a strong expectation of the College.

In a Level 2 hospital, cover by an appropriate hospital medical officer (resident) is expected from 8 am to 10 pm.

In a Level 1 hospital cover for the registrars by an appropriate hospital medical officer (resident) is not expected.

- 6.2.11 **Experience in clinics – metropolitan sites.** Trainees at Level 2 and Level 3 hospitals must be provided with experience in the care of a broad range of non-hospitalised patients seen in the specialty and also those presenting with urgent problems. Each trainee must be given the opportunity, under the supervision of a consultant, to provide an initial assessment and consultative service to patients presenting with emergency conditions. In particular, regular rostered access to a formal gynaecology clinic – not simply a pre-operative gynaecology clinic – is essential.

## STANDARD 6:

### PROVISION OF CORE LEVELS OF CLINICAL EXPERIENCE - COMPETENCY AND IN-HOUSE CREDENTIALING ISSUES (Cont.)

- 6.2.12 **Experience in clinics – rural sites.** While the experience in clinics available to trainees at rural sites is necessarily limited, the roster should ensure that the trainees have all available experience in this area; eg access to gynaecology and antenatal clinics if available or, at least, a pre-operative anaesthetic clinic.
- 6.2.13 **Protocols.** As part of the implementation of consistent, up-to-date and safe training practices, the hospital should ensure that all birthing suite and gynaecology protocols are regularly reviewed and revised, and consistently followed by all consultants.
- 6.2.14 **Birthing suite handover – 8 am.** The 8 am birthing suite handover should be seen as a vital educational opportunity for registrars, as well as an essential time for proactive planning (triaging for the birthing suite). The consultant on duty, the senior registrar and the team leader/midwife should be present at handovers in a tertiary hospital. Ideally, these handovers should be multi-disciplinary, with the inclusion of the paediatrician and the anaesthetist. The amount of teaching provided at these handovers will, of course, vary according to the patient load.
- 6.2.15 **Training in private settings.** In cases where a hospital is unable to offer comprehensive training in a specific area of O&G, the hospital shall actively support the relevant ITP Co-ordinator/Training Supervisor in making arrangements to send trainees to another accredited site for periods of prescribed training or to private settings (in which case the trainee's indemnity insurance should be covered by the hospital as part of its training responsibility to its registrars). Patients must give informed consent if being attended by trainees in a private setting and care must be taken to ensure that the registrar has follow-up with the same patients whenever possible.

### 6.3 In-house credentialing of registrars

- 6.3.1 **Documented credentialing process for accredited and non-accredited registrars.** As part of the hospital's responsibility to ensure the attainment of clinical competency by trainees at the appropriate level, and to ensure that they are provided with the necessary level of consultant support, the hospital should have implemented a documented credentialing process to identify each trainee's competence in core obstetric and gynaecological surgical procedures.

**IMPORTANT NOTE:** The credentialing process is intended to identify each registrar's level of competency and confidence for various key surgical procedures and is a guide for the consultants and other staff at that particular hospital; it must not be confused with, or regarded as a substitute for, the RANZCOG process of formal assessment of trainee surgical competency (see Item 6.1 above). The in-hospital credentialing process is the responsibility of the Training Supervisor/staff specialist in collaboration with consultants and senior registrars.

- 6.3.2 **Responsibility of consultants.** The credentialing document should indicate whether each registrar is competent to perform a specific procedure supervised or unsupervised, particularly after hours. If a registrar is listed as requiring after hours supervision for a procedure, it is a high priority expectation that the on-call consultant come in for that registrar and that procedure until such time as the registrar is signed off as being competent in that procedure. Even in the event that a trainee is considered competent in a procedure, this does not preclude him/her from seeking assistance from a consultant should the trainee feel that assistance is needed, nor does this preclude the consultant providing such support when requested to.

## STANDARD 6:

### PROVISION OF CORE LEVELS OF CLINICAL EXPERIENCE - COMPETENCY AND IN-HOUSE CREDENTIALING ISSUES (Cont.)

- 6.3.3 **Procedures covered by credentialing.** The credentialing document, prepared by appropriate O&G department staff, should cover at least the following procedures:
- a) delivery with significant maternal risk;
  - b) forceps delivery;
  - c) lower uterine segment Caesarean section - with added complication;
  - d) lower uterine segment Caesarean section;
  - e) rotational vacuum delivery;
  - f) non-rotational vacuum delivery;
  - g) vaginal breech delivery;
  - h) twin delivery;
  - i) laparoscopy – Levels 1 & 2;
  - j) laparoscopy – Level 3: operative; and
  - k) D&C.
- 6.3.4 **Acting in accordance with credentialing process.** The document should be distributed to all consultants and senior midwifery staff, and reviewed and updated for each trainee every six months. It must be clearly understood by trainees, supervisors, consultants, midwifery staff and senior registrars that if the credentialing document lists a trainee as requiring supervision for a specific procedure such a trainee must not be permitted to open theatre on their own. In the event of an emergency, however, it may be necessary for a registrar to commence a procedure for which they are not credentialed. In these situations the responsible consultant should be notified by the registrar or next available senior staff member and attendance in theatre requested urgently.
- 6.3.5 **Credentialing at rural sites.** While consultant support and supervision at rural hospitals is usually close and extremely hands-on, a formal, documented in-hospital credentialing process is still necessary since there may be times when locum consultants are on duty who are not familiar with the trainees' level of competence. In compiling the credentialing document the rural hospital should verify with the home/base hospital the credentialing situation with each of their allocated registrars; the hospital should not simply rely on the registrars' own assessment of their capabilities.

## STANDARD 7:

### REGISTRAR STAFFING, SAFE WORKING HOURS AND LEAVE ARRANGEMENTS

## STANDARD 7: REGISTRAR STAFFING, SAFE WORKING HOURS AND LEAVE ARRANGEMENTS

Each hospital will employ an adequate number of registrars and residents to ensure the workload for junior medical staff is reasonable such that there are adequate opportunities for training, and award conditions are complied with.

### CRITERIA

#### 7.1 Appropriate registrar numbers

- 7.1.1 **Registrar staffing.** It is recognised that in most hospitals there is a conflict between clinical service needs and training requirements. Registrar numbers should be adequate to ensure appropriate training opportunities and meet with the approval of the relevant head of the O&G department.

#### 7.2 Appropriate working hours and shift work

- 7.2.1 **RANZCOG policy.** The College recognises that hospital medical practice sometimes requires onerous shift work and the working of extended hours for service provision and continuity of care. At the same time, it has a responsibility to its trainees to address the risks that fatigue and sleep deprivation create for both the individual health and safety of the registrar and for the quality of care given to the patient. While recognising that this issue is a matter for employers and the applicable awards/contracts, the College's standards in this area are guided primarily by the Australian Medical Association's (AMA's) *National Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors (1999)*, as well as by individual state/regional Occupational Health and Safety legislation and stipulations by the New Zealand Resident Doctors' Association. The College policy also incorporates allowance for the varying workloads at each accredited site, its level of nursery and the extent of resident support of its registrars after hours.

The College accepts that the AMA Code of Practice may not be accepted or adhered to by all health jurisdictions. Where this is the case, the College would expect individual employers to adhere to the relevant award conditions in relation to working hours and shift work.

- 7.2.2 **Guide to appropriate hours.** The *AMA National Code of Practice*, by which the College is guided, identifies 50 to 70 hours worked in a 7-day period as a significant risk, with more than 70 hours worked in that same period as representing higher risk. Balancing this guideline with the need to ensure that conditions of employment are not so restrictive as to impact on trainees' ability to access required O&G experience – and to allow time for the close supervision, hands-on training and follow-up essential for learning good clinical practice – the College believes the following is a reasonable guide to conditions which accredited hospitals should work towards in collaboration with the RANZCOG:

- 7.2.2.1 Registrar hours worked in a 7-day period should comply with the appropriate award applicable in the relevant state/region. However, anything above 60-70 per week on a consistent basis would be regarded as placing an excessive burden on the trainee.

## STANDARD 7:

### REGISTRAR STAFFING, SAFE WORKING HOURS AND LEAVE ARRANGEMENTS (Cont.)

- 7.2.2.2 As a guide to hospitals, the College recommends that the maximum length of a registrar's shift should be 16 hours.
  - 7.2.2.3 It is acceptable for a registrar's shift to occasionally include 24-hour duties provided this is voluntary, always followed by a day off and occurs at hospitals where there is 24-hour resident cover and ready availability of consultant support to ensure the shift is not onerous.
  - 7.2.2.4 Depending on the size of the hospital and the number of registrars on staff, weekend rosters should not be organised on less than a 1:3 basis; the use of a 1:2 roster on a consistent basis would be regarded as a last resort and then only if the staffing difficulties at a particular site allowed no other option.
  - 7.2.2.5 Accredited hospitals which continually roster registrars for 60 to 72-hour shifts or for 48-hour shifts would generally be regarded as being outside the safe working hours guidelines. However, the College does acknowledge the situation for those smaller hospitals, particularly in rural areas, where there is only one registrar and he/she is required to be on-call over the weekend, provided the registrar can easily access consultant support when needed and the actual workload is not excessive.
- 7.2.3 **Physical safety and security\***. Since many specialist trainees work extended hours and/or are subject to on-call and call-out arrangements which require them to attend and leave the hospital workplace at unusual hours, the employing hospital should ensure the safety and security of doctors by addressing the following areas:
- 7.2.3.1 Physical safety and security, such as lighting and escorts, when leaving work and reaching their car or transport at times well outside normal business hours.
  - 7.2.3.2 Provision of taxis or other transport when work-induced fatigue makes it unsafe for the doctor to drive home in their own car.

### 7.3 Arrangements for registrars on-call

- 7.3.1 **Availability.** Registrars on-call after hours should be paid to remain on-site overnight or, if this is not practicable, they should be available within 30 minutes (i.e. the same requirement applicable to consultants who are on-call after hours).
- 7.3.2 **Rest/on-call room.** Hospitals should provide a rest/on-call room of some description for registrars when they are on night duty.

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\* For further information on this area refer to the Australian Medical Association's Position Statements Personal Safety and Privacy for Doctors 2005 <http://www.ama.com.au/web.nsf/doc/WEEN-6JVUGZ> and Workplace Facilities and Accommodation for Hospital Doctors 2006 <http://www.ama.com.au/web.nsf/doc/WEEN-6MV9QE>

## STANDARD 7:

### REGISTRAR STAFFING, SAFE WORKING HOURS AND LEAVE ARRANGEMENTS (Cont.)

#### 7.4 Appropriate leave arrangements

- 7.4.1 **RANZCOG policy.** Irrespective of the leave entitlements available to trainees in particular states, regions or hospitals, the College's leave stipulation is that in any one training year each ITP trainee must complete a minimum of 44 weeks of active clinical service and formal training, or 22 weeks of part-time training; i.e. the trainee is entitled to eight weeks of leave of any kind. This includes annual leave, maternity leave, extended sick leave, family leave or leave without pay. Any leave arrangements made by trainees should not reduce the stipulated minimum of 44 weeks of clinical work.
- 7.4.2 **Study/Conference leave.** In addition to the eight weeks' leave stipulated above, trainees are permitted up to two weeks of study/conference leave per year, which is recognised as part of active clinical service.

## STANDARD 8:

### EDUCATIONAL RESOURCES

## STANDARD 8: EDUCATIONAL RESOURCES

Hospitals shall ensure that the structured educational program is supplemented by an adequate range of educational resources as part of the hospital's obligation to provide a supportive learning environment.

### CRITERIA

#### 8.1 Provision of Information Technology/library facilities at all accredited sites:

- ready access to Personal Computers (PCs), (including the Internet and medical databases), with at least one PC permanently located in the registrars' room;
- password access, if required by the hospital in order to access databases like PubMed, should be easily available to all registrars;
- access to the library after hours; and
- an extensive and up-to-date library collection and/or access to an efficient interlibrary loan facility.

#### 8.2 Provision of leave/financial support for professional development\*

It is an expectation of the College that the following would be part of any negotiated award or contract, or would be a standard which the employer would work towards in collaboration with the RANZCOG:

- 8.2.1 **Conferences and seminars.** Hospitals, particularly those in remote rural areas, should allow trainees time off – on a rostered basis – to attend conferences and seminars.
- 8.2.2 **Reimbursement.** The College encourages hospitals to consider at least partially reimbursing trainees for costs involved in attending conferences and workshops.

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\* That is, where such support is not already in place.

## STANDARD 9:

### RURAL HOSPITALS - SUPPORT SERVICES, FACILITIES AND GUIDELINES SPECIFICALLY RELATING TO RURAL TRAINING

#### STANDARD 9: RURAL HOSPITALS - SUPPORT SERVICES, FACILITIES AND GUIDELINES SPECIFICALLY RELATING TO RURAL TRAINING

**Accredited rural sites (defined as a site more than 50km from the home/base hospital in the relevant ITP) shall provide the following support, training and supervision to trainees on rotation to ensure they are able to perform effectively and are appropriately trained.**

[Note: For the convenience of the reader this section also includes those guidelines specifically relating to rural training which have appeared in earlier sections. All other guidelines in the previous sections of this document apply equally to rural and metropolitan sites, unless otherwise stated.]

#### CRITERIA

##### 9.1 Appropriate assistance and facilities

The College regards the following as appropriate guidelines for hospitals when negotiating awards or contracts:

- a) hospital accommodation or other subsidised accommodation, or assistance in obtaining suitable accommodation for the trainee and his/her family;
- b) removal expenses to and from the rural location;
- c) travel expenses to and from the rural location;
- d) funding for at least two home visits by the trainee in every six-month period, either in full or not less than 50 per cent of the cost;
- e) provision of interstate telephone facilities; and
- f) internet facilities for use not only in training, but also for communication with the College and other trainees.

##### 9.2 Structured educational program

As part of its obligations as a training site to provide a supportive learning environment to its trainees, the rural hospital should ensure appropriate rostered and protected learning opportunities. While rural sites are not expected to provide the comprehensive formal educational program required of a major metropolitan hospital, they should provide a program which includes the following:

- a) regular teaching session;
- b) combined case review meeting looking at Caesarean sections and any vaginal deliveries (where the registrars are required to present a case or audits on Caesarean/instrumental deliveries on a regular basis); and
- c) perinatal morbidity/mortality meetings (approximately every three months).

##### 9.3 Research opportunities and active encouragement of research

While research activity is not normally a priority at peripheral or rural sites, these sites are expected to encourage trainees' research interests wherever possible; eg by encouraging them to participate in obstetric audits, assist in the review and writing of protocols, etc.

## STANDARD 9:

### RURAL HOSPITALS - SUPPORT SERVICES, FACILITIES AND GUIDELINES SPECIFICALLY RELATING TO RURAL TRAINING (Cont.)

#### 9.4 Theatre lists

Each trainee in a rural setting should have access to 2 – 3 major lists per week and 1 – 2 day surgery lists, depending on the size of the hospital and the available caseload.

#### 9.5 Appropriate experience in clinics

The experience in clinics available to trainees at rural sites is necessarily limited; however the roster should ensure that the trainees have all available experience in this area, eg access to gynaecology and antenatal clinics if available, or at least a pre-operative anaesthetic clinic.

#### 9.6 In-hospital credentialing

As part of the rural hospital's responsibility to ensure the attainment of clinical competency by trainees at the appropriate level, and to ensure that they are provided with the necessary level of consultant support, the hospital should have implemented a documented credentialing process. This process should identify each trainee's competence in core obstetric and gynaecological surgical procedures and the degree to which he/she requires consultant supervision/assistance, particularly after hours. While consultant support and supervision at rural hospitals is usually close and extremely hands-on, a formal documented in-hospital credentialing process is as essential for a rural site as for a major metropolitan one since there may be times when locum consultants are on duty who are not familiar with a trainee's level of competence.

In compiling the credentialing document the rural hospital should verify with the home/base hospital the credentialing situation with each of their allocated registrars; the hospital should not simply rely on the registrars' own assessment of their capabilities.

For the College's guidelines on in-hospital credentialing for all accredited sites see Standard 6 – Items 6.3.1 to 6.3.5 above.

# Appendices

**Appendix 1:**      **Hospitals Accredited by RANZCOG for the Integrated Training Program**

**Appendix 2:**      **Abbreviations**

**Appendix 3:**      **Glossary of Terms**



## APPENDIX ONE:

# HOSPITALS ACCREDITED BY RANZCOG FOR THE INTEGRATED TRAINING PROGRAM

## APPENDIX ONE: HOSPITALS ACCREDITED BY RANZCOG FOR THE INTEGRATED TRAINING PROGRAM

[Note: Hospitals marked with an asterisk are rural rotations. The home/base hospital in each individual ITP is indicated in bold.]

### AUSTRALIA

State	ITP	HOSPITALS INVOLVED
Victoria	Mercy Hospital for Women	<b>Mercy</b> Bendigo* Western Geelong* Ballarat* Wangaratta Base* Northern (Epping) Warrnambool* Wodonga*
	Monash Medical Centre	<b>Monash</b> Dandenong Box Hill Sandringham & District Memorial Angliss Launceston General* Mildura
	The Royal Women's Hospital	<b>Royal Women's</b> Geelong* Western Ballarat* Warrnambool* Northern (Epping) Wodonga*
NSW and ACT	The Canberra Hospital	<b>Canberra</b> Calvary Wagga Wagga Woollongong
	The St George Hospital	<b>St George</b> Bankstown Sutherland Lismore Base* Woollongong
	The John Hunter Hospital	<b>John Hunter</b> Belmont District Maitland* Gosford

## APPENDIX ONE:

### HOSPITALS ACCREDITED BY RANZCOG FOR THE INTEGRATED TRAINING PROGRAM (Cont.)

State	ITP	HOSPITALS INVOLVED
NSW	The RPA Hospital	<b>RPA Women's and Babies</b> Canterbury Gosford*
	Northern Sydney	<b>Royal North Shore</b> Hornsby Salisbury (UK) Port Macquarie*
	Western Sydney	<b>Westmead</b> Auburn Blacktown Dubbo* Coffs Harbour*
	The Nepean Hospital	<b>Nepean</b> Westmead Orange Base* St Michael's (Bristol, UK)
	The Royal Hospital for Women	<b>Royal Hospital for Women</b> Wollongong Tamworth*
	The Liverpool Hospital	<b>Liverpool</b> Fairfield District Bankstown* Tweed/Murwillumbah* Campbelltown
SA and NT	South Australia/Northern Territory	<b>Flinders Medical Centre/ Lyell McEwin</b> Queen Elizabeth Modbury Royal Adelaide Mt Gambier and Millicent* Women's and Children's Royal Darwin*
QLD	Caboolture	<b>Caboolture*</b> Mater Mothers' Gold Coast
	Mater Hospital I	<b>Mater Mothers'</b> Logan* Cairns Base* QEII

## APPENDIX ONE:

### HOSPITALS ACCREDITED BY RANZCOG FOR THE INTEGRATED TRAINING PROGRAM (Cont.)

State	ITP	HOSPITALS INVOLVED
QLD	Mater Hospital II	<b>Mater Mothers'</b> Nambour* Toowoomba*
	The Royal Brisbane and Women's Hospital I	<b>Royal Brisbane and Women's</b> Gold Coast* Ipswich
	The Royal Brisbane and Women's Hospital II	<b>Royal Brisbane and Women's</b> Redcliffe Bunderberg*
	The Logan I	<b>Logan</b> Mater Mothers' Rockhampton Base* QEII
	The Logan II	<b>Logan</b> Mater Mothers' Mackay Base* QEII
	Gold Coast Hospital I	<b>Gold Coast</b> Royal Brisbane and Women's Townsville*
	Gold Coast Hospital II	<b>Gold Coast</b> Royal Brisbane and Women's Nambour*
	Redcliffe Hospital	<b>Redcliffe</b> Royal Brisbane and Women's Caboolture
	Nambour Hospital I	<b>Nambour General</b> Royal Brisbane and Women's Caboolture* Townsville*
	Nambour Hospital II	<b>Nambour General</b> Royal Brisbane and Women's Townsville*

## APPENDIX ONE:

### HOSPITALS ACCREDITED BY RANZCOG FOR THE INTEGRATED TRAINING PROGRAM (Cont.)

State	ITP	HOSPITALS INVOLVED
QLD	Townsville Hospital	<b>Townsville</b> Royal Brisbane and Women's Caboolture
	Redlands Hospital	<b>Redlands</b> Mater Mothers' Gold Coast
	Ipswich I	<b>Ipswich</b> Mater Mothers' Gold Coast*
	Ipswich II	<b>Ipswich</b> Nambour* Royal Brisbane and Women's
	Cairns	<b>Cairns</b> Townsville* Mater Mothers'
	Toowoomba	<b>Toowoomba</b> Mater Mothers' Logan
WA	King Edward Memorial Hospital	<b>King Edward Memorial</b> Joondalup Health Campus Osborne Park Bunbury* Fremantle
TAS	Royal Hobart Hospital	<b>Royal Hobart</b> Launceston General*
<b>NEW ZEALAND</b>		
	Northern	<b>Auckland City</b> New Plymouth Tauranga* Middlemore Waikato
	Central	<b>Wellington Women's</b> Palmerston North Hawkes Bay*
	Southern	<b>Dunedin</b>

**APPENDIX TWO: ABBREVIATIONS**

<b>AC</b>	Abdominal circumference
<b>BPD</b>	Biparietal diameter
<b>CRL</b>	Crown Rump Length
<b>D&amp;C</b>	Dilatation and Curettage
<b>FL</b>	Femur length
<b>FRANZCOG</b>	Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists
<b>HC</b>	Head circumference
<b>ITP</b>	Integrated Training Program
<b>LUSCS</b>	Lower Uterine Segment Caesarean Section
<b>MRANZCOG</b>	Member of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists
<b>O&amp;G</b>	Obstetrics and Gynaecology
<b>RANZCOG</b>	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
<b>REI</b>	Reproductive Endocrinology and Infertility
<b>TA imaging</b>	Trans Abdominal imaging (ultrasound)
<b>TAH</b>	Total Abdominal Hysterectomy
<b>TV imaging</b>	Trans Vaginal imaging (ultrasound)

## APPENDIX THREE:

### GLOSSARY OF TERMS

#### APPENDIX THREE: GLOSSARY OF TERMS

<b>Accreditation</b>	The formal process by which a hospital obtains recognition and approval from the RANZCOG as a training site for the Integrated Training Program. Re-accreditation is the formal process by which the College determines if this recognition and approval should continue, based on the effectiveness of the training, supervision and support provided to the trainees at the hospital.
<b>Accredited Hospital</b>	A hospital which has been accredited by the RANZCOG as a training site for the Integrated Training Program.
<b>Consultant</b>	A full-time or sessional specialist in obstetrics/gynaecology and a Fellow of the College with whom a trainee works and trains in an accredited RANZCOG training site.
<b>Credentialing</b>	A documented in-hospital process where the appropriate O&G department staff working with and overseeing trainees assess their competency in a range of surgical procedures and determines from that assessment the degree of supervision required, particularly after hours.
<b>Elective Program (EP)</b>	A prospectively approved and planned two-year training program in an area of interest to trainees, usually as part of their post-Membership training.
<b>Fellowship (FRANZCOG)</b>	The qualification awarded to a trainee, subject to approval by Council, who has satisfactorily completed all assessment and administrative requirements for the designated 72 months of MRANZCOG/FRANZCOG training.
<b>Integrated Training Program (ITP)</b>	The four years of planned clinical, educational and assessment requirements leading to Membership of the RANZCOG (MRANZCOG). An individual ITP is a consortium of hospitals in a particular area which has agreed to provide such training.
<b>Level 1 Hospital*</b>	A country district or smaller metropolitan hospital staffed by rostered obstetricians, resident medical staff and midwives and providing care for mothers and infants at low to moderate risk. Accredited general practitioners and a specialist anaesthetist are on-call. The hospital has a neonatal care unit that can give low-level oxygen and has a paediatrician on-call.

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\*Adapted from the standard hospital level designations as defined in the *NSW Public Health Bulletin, Supplement, December 2005, Volume 16, Num S-4*

## APPENDIX THREE:

### GLOSSARY TERMS (Cont.)

<b>Level 2 Hospital*</b>	A country base or metropolitan district hospital staffed by obstetricians and a paediatrician available 24 hours a day, 7 days a week, providing delivery and care for mothers/babies with moderate risk factors. A rostered medical staff specialist anaesthetist is on-call and there is also paediatric house staff. The hospital has a neonatal care unit that can give high-level oxygen and can start mechanical ventilation if necessary.
<b>Level 3 Hospital*</b>	Also known as a tertiary hospital. A specialist obstetric hospital which is supra regional and staffed by both full-time and sessional consultants, as well as having staff neonatologists and neonatal registrars. The hospital deals with low, moderate and high-risk births and has a Neonatal Intensive Care Unit (NICU), which provides high-dependency specialist nursing and medical care for all newborn infants, including sustained life support such as mechanical ventilation.
<b>Membership (MRANZCOG)</b>	The qualification awarded to a trainee, subject to approval by Council, who has satisfactorily completed all assessment requirements for the 48 months of prospectively approved MRANZCOG training, including the Distance Education Program, the In-hospital Clinical Assessment modules and workshops requirements, and the MRANZCOG Written and Oral Examinations.
<b>Program Co-ordinator</b>	A consultant and Fellow of the College responsible for planning and co-ordinating a local Integrated Training Program involving a consortium of at least two hospitals in a particular area.
<b>Regional/New Zealand Training and Accreditation Committees</b>	RANZCOG committees covering Australian states and territories and New Zealand responsible for the appointment of Program Co-ordinators and Training Supervisors, and reviewing applications by prospective MRANZCOG/FRANZCOG trainees in the relevant state, territory or country. These committees also review the training documentation and progress of said trainees.
<b>Rotation</b>	A planned period of training undertaken by a trainee at a designated site within an ITP, lasting for a minimum of six months and a maximum of 12.
<b>Rural Rotation</b>	A planned period of at least six months' training at an accredited rural hospital, which all RANZCOG trainees must undertake in the course of the six-year training program (ideally during their ITP years).
<b>Rural Site</b>	An accredited hospital which is at least 50km from the home/base hospital in the relevant Integrated Training Program.
<b>Training and Accreditation Committee of RANZCOG</b>	A standing committee of Council responsible for the development and maintenance of the training and assessment requirements for the MRANZCOG/FRANZCOG, the approval of training hospitals and posts, the review of Integrated Training Programs and the consideration of applicants for Membership and Fellowship. This Committee is also known as the College Training and Accreditation Committee.

\*Adapted from the standard hospital level designations as defined in the *NSW Public Health Bulletin, Supplement, December 2005, Volume 16, Num S-4*

## APPENDIX THREE:

### GLOSSARY TERMS (Cont.)

<b>Training Post</b>	A hospital position in an accredited hospital, which has been accredited by the RANZCOG as suitable for training towards the MRANZCOG/FRANZCOG.
<b>Training Program</b>	A structured six-year postgraduate program leading firstly to certification as a Member (MRANZCOG) and then to elevation as a Fellow (FRANZCOG) of the College.
<b>Training Supervisor</b>	A consultant and Fellow of the College, who is a member of staff in an accredited hospital, responsible for the co-ordination and ongoing supervision of RANZCOG trainees in that hospital, including the regular formative and summative assessments of the trainee/trainees for whom he or she is responsible.



