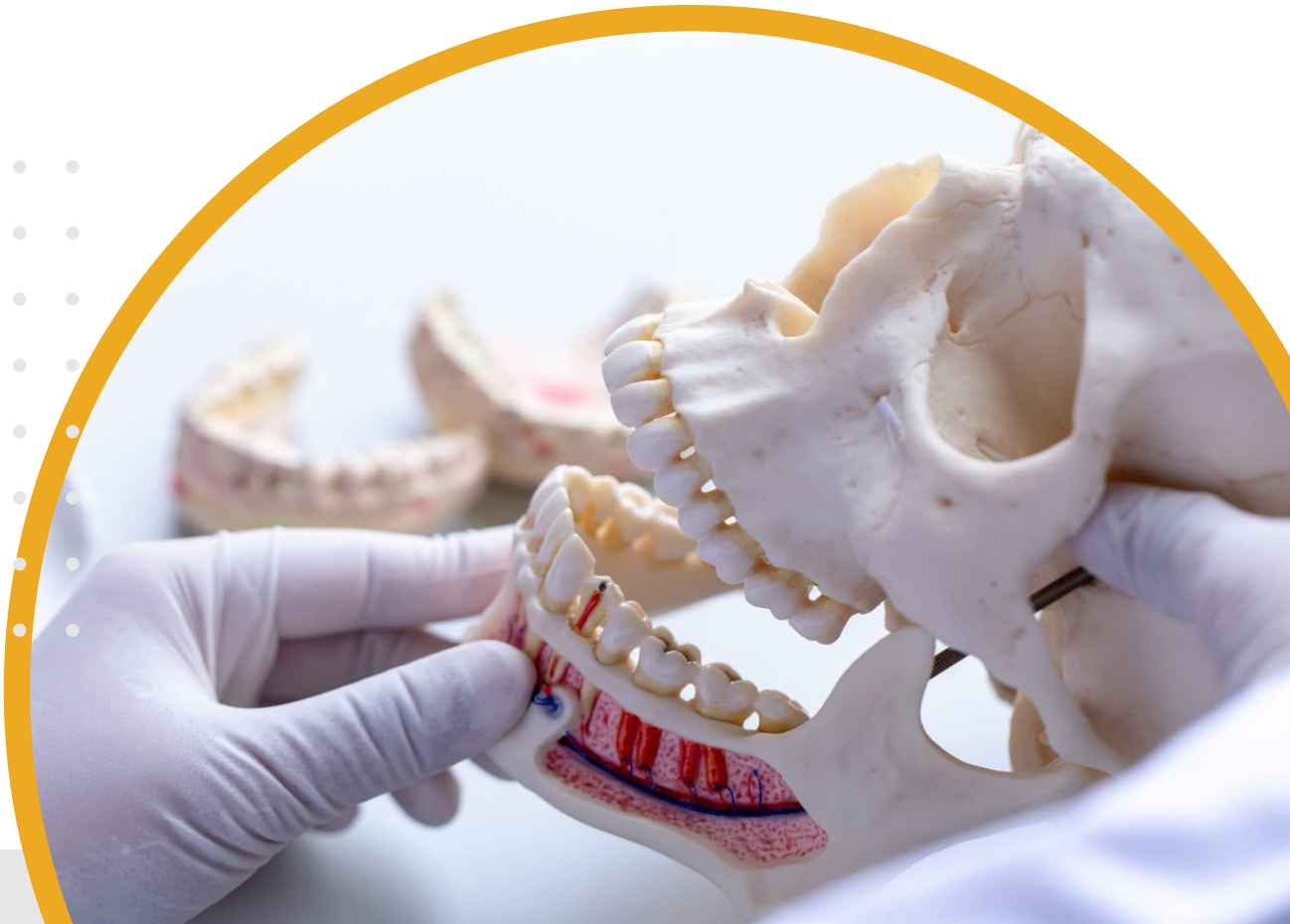
Royal Australasian College of Dental Surgeons
Let knowledge conquer disease

RACDS

Standards and Criteria for Accreditation of Regional Training Centres, Hospitals and Posts



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1. ACCREDITATION OF TRAINING POSTS

1.1 The Royal Australasian College of Dental Surgeons (the College) accredits training posts within institutions in Australia and New ZealandExamples of institutions include a hospital, an oral health centre or a private practice The aim of the accreditation process is to ensure that all training posts provide an appropriate learning environment that fosters the training of safe and component Oral and Maxillofacial Surgeons.

1.2 A Regional Training Centre is defined as a group of accredited training positions/posts. Each individual accredited training post has an accreditation status that is awarded based on the post's individual performance against the RACDS Standards and Criteria for Oral and Maxillofacial Surgery (SCOMS).

2. ACCREDITATION OUTCOMES

2.1 There are three possible outcomes of application for accreditation of a training post:

a) Full accreditation is granted to a post when all mandatory requirements have been met, and the College is satisfied that the core requirements for accreditation have been achieved.

b) Conditional accreditation granted to a post when the mandatory criteria have not been met, but the College is satisfied that there is the potential for significant progress to be made within the next 12 months. The training institution would be required to report progress within 12 months of the review.

c) Accreditation is not granted or withdrawn to a post when the mandatory criteria have not all been met, and the College is not satisfied that significant progress can be made within the next 12 months. The training institution can re-apply for accreditation after 12 months.

2.2 It is the responsibility of the Director of Training (DoT) to notify the College of any significant change to a post within the Regional Training Centre. The College will then determine if the post requires reassessment. The responsibility of the College is primarily towards the trainee and their continuation of training.

3. ACCREDITATION CYCLE AND MONITORING

3.1 Posts that receive full accreditation will be reviewed through a five-year accreditation cycle.
3.2 Posts that receive conditional accreditation will be reviewed at the appropriate 12-month stage.
3.3 The College reserves the right to request an accreditation review of a Regional Training Centre within the five (5) year accreditation period.

4. ACCREDITATION OF A NEW TRAINING POST

4.1 Application for accreditation of all new and potential training posts must occur before an accredited trainee can occupy the post. The process for application is as follows:

a) The DoT, in conjunction with the relevant Regional Surgical Committee, writes to the OMS Accreditation Committee with notification that a new training post is being offered.

b) The proposed Supervisor of Training (SoT) completes the application for accreditation of an additional or new OMS training post (see Appendix 1).

c) The Accreditation Committee reviews the documentation and requests any additional information that may be required.

d) The Accreditation Committee considers the application and nominates an accreditation review team. The accreditation review team is responsible for the review of the post, assessing suitability against SCOMS. If the post is in a hospital which does not have a current accredited training post, a site visit may be warranted.

e) On behalf of the College, the Accreditation Committee makes a final decision about the accreditation status of the post based on recommendations from the review team. The OMS Board of Studies and College Board are informed.

f) Once full accreditation status has been achieved by a post, it will enter onto that training centre's review cycle.

5. ACCREDITATION REVIEW OF A REGIONAL TRAINING CENTRE

5.1 Process

5.1.1 This section describes the process involved in the accreditation review of a Regional Training Centre, involving site visits. The process is defined below:

a) The Accreditation Committee nominates an accreditation review team.

b) The Regional Surgical Committee is notified by the College prior to an accreditation review. The Chair of the Accreditation Committee through the OMS Education Officer will write to the DoT and Chair of the Regional Surgical Committee proposing dates for the visit to occur. The Training Centre will be advised of the approximate length of the visit, and it will be requested that the final date is agreed with the College no less than eight (8) weeks prior to the visit.

c) A letter is sent to each institution's SoT and Head of Unit or Section, detailing when their post will be reviewed and with whom the accreditation team would like an interview, including medical / surgical administration.

d) The College forwards to the SoT of each institution a pre-visit accreditation survey (see Appendix 1) and draft itinerary which is to be completed and returned within four (4) weeks.

e) The overall visit itinerary is prepared by the OMS Education Officer in consultation with the DoT, the Chair of the Regional Surgical Committee, and the SoT for each post. At the time of each institution visit, it is the responsibility of the SoT to ensure that incumbent trainees are available for interviewing and that up-to-date learning portfolios and logbook summaries are available. The SoT is responsible for contacting and confirming the appointments for all the relevant stakeholders for their institutions visit.

f) The accreditation review team reviews the returned pre-visit survey and identifies any outstanding information that may be required prior to the visit. In conjunction with the College, the review team will finalise a site visit program with the DoT, SoT(s) and Chair of the Regional Surgical Committee.

5.2 The Site Visit

5.2.1 The College retains the right to visit all sites involved in OMS training. The purpose of site visits is to allow both the training institutions and the College to confirm the information provided in the pre-visit survey and to allow the hospital to provide any outstanding information or address any queries based on the available documents.

5.2.2 Site visits will usually consist of multiple interviews with significant stakeholders involved in the provision of training. The SoT for each hospital will arrange the meeting room, A-V requirements and any catering that is required during the review teams visit to the hospital.

5.3 Accreditation Review Team

5.3.1 The accreditation review team will be appointed by the Accreditation Committee.

5.3.2 The accreditation review team should consist of at least:

a) Two (2) Senior Oral Maxillofacial Surgeons – These individuals should have experience in supervision and training in a hospital like that seeking accreditation and be from a state or country other than the one being accredited. He or she will usually be a member of the Accreditation Committee and be experienced in conducting accreditation reviews.

b) A senior staff member from the RACDS – Education and Training, such as the OMS Education Officer.

5.4 Provision of Reports and Opportunity for Review

5.4.1 The provision and review of reports will follow the following process:

a) The accreditation review team prepares a draft Preliminary Report for review and endorsement by the Accreditation Committee within six (6) weeks after the site visit. The Preliminary Report includes the pre-visit survey.

b) The OMS Education Officer, on the direction of the Chair of the Accreditation Committee, emails a copy of the Preliminary Report to the DoT, SoT, Chair of the Regional Surgical Committee, Director of Surgery, and Director of Medical Services or equivalent of each training post for factual accuracy and comment. All comments must be received in writing within three (3) weeks to be considered.

c) The Accreditation Committee considers comments, amends the Preliminary Report, and approves it as the Final Report. The approved Final Report is sent for ratification by the Board of Studies, OMS, and noted by the College Board of Directors.

d) The commencement date of the accreditation period will be the date that the Final Report is ratified by the Board of Studies, OMS.

e) The OMS Education Officer emails a copy of the ratified Final Report to all relevant parties.

5.5 Withdrawal of Accreditation

5.5.1 The College reserves the right to request an accreditation review of a training post within the five (5) year accreditation period. Such a review may be initiated after advice from the institution or Regional Surgical Committee that a significant change to the quality of training has occurred. A complaint from a Fellow or Trainee, for example, may also precipitate the need for a review of a training post/s.

5.5.2 Accreditation status of a training post may be altered if the training post no longer meets the accreditation standards and criteria. The College will work with a training institution to make the required improvements in a realistic timeframe. The College would also be available to support training institutions in negotiations with jurisdictions. Full accreditation status would be withdrawn only if the training post failed to meet mandatory accreditation criteria and negotiations with the institution involved consistently fail to produce a workable outcome.

5.5.3 In view of the seriousness of withdrawing accreditation of a training post, the final decision on taking such action will be made by the CEO, the Chair of the Board of Studies and the Chair of the Accreditation Committee in close consultation with the relevant review team and the relevant Regional Surgical Committee.

5.6 Notification of Changed Circumstances and Implications

5.6.1 An institution with an accredited training post should notify the College when there will be, or if there has been, any significant change to the way in which education and/or training is delivered or monitored. This is particularly the case if the change affects the institution meeting accreditation standards and criteria as published in SCOMS. The institution may do this by completing an interim accreditation survey (see Appendix 1).

5.7 Appeals Process

5.7.1 Apart from appeals concerning trainees who have been adversely affected, only appeals that are based on errors in process will be considered. Complaints must be lodged with the CEO of the College in line with the College Complaints Policy. The complaints will be reviewed by a constituted College Appeals Committee. Such applications shall be in writing and accompanied by all relevant information or grounds upon which the person seeks to rely in respect of the review.

6. RACDS STANDARDS AND CRITERIA FOR ORAL AND MAXILLOFACIAL SURGERY (SCOMS)

The following criteria are the mandatory requirements that must be achieved with the hospital network seeking accreditation.

Standard 1 – Education and Training **The training program is appropriately delivered, managed, and evaluated.**			
Accreditation Criteria	**Assessed by**	**Minimum Requirements**	**Standard MET, UNMET or MET WITH EXCEPTION**
1.1 Co-ordinated schedule of learning experiences for each trainee	• Weekly timetable of activities which incorporate learning needs. • Range of teaching methods used to deliver modules.	• Evidence of formal, structured didactic tutorials, held on a weekly basis. • Evidence of a variety of educational resources for trainees.	
1.2 Clinical Training Assessment	• Implementation of RACDS assessment strategy. • Presentation of individual trainee portfolios. • Feedback from trainees.	• Supervisors of training are conducting mid-term (three-month progress) assessments and completing six-month formative assessments. • Evidence trainees are completing work-based assessments appropriate for level of training.	
1.3 Access to external educational activities for trainees	• Documented hospital HR Policy on educational leave for trainees. • Summary data of leave taken • Feedback from trainees.	• Trainees given leave to attend mandatory courses. • Evidence to support leave is provided.	

1.4 Opportunities for research.	• Recent or current research publications. • Feedback from trainees.	• Evidence of regular research meetings. • Trainees allowed access to medical records for research where appropriate and ethics approved. • Trainee research projects are progressing and are at an appropriate stage for year of training.	

Standard 2 – Clinical Experience **Trainees must be able to access clinical experience and educational opportunities that enable them to attain the required competencies and proficiencies required by the RACDS training program.**			
Accreditation Criteria	**Assessed by**	**Minimum Requirements**	**Standard MET, UNMET or MET WITH EXCEPTION**
2.1 Supervised consultant outpatient clinics	• Documentation on frequency of consultative clinics. • Documentation showing trainees see new patients and follow up / review patients.	• Trainees attend a minimum of one (1) consultative clinic per week. *or* the equivalent of four (4) consultative clinics per month. • Trainees see new and review patients under supervision. • Trainees attend alternative supervised consultative clinics.	
2.2 Beds available for OMS	• Documentation on accessible beds for OMS.	• Sufficient beds to accommodate caseload.	
2.3 Consultant led ward rounds with educational and clinical goals	• Documentation on the frequency of consultant led scheduled ward rounds. • Feedback from trainees.	• Trainees attend a minimum of one (1) consultant led ward round per week.	
2.4 Caseload and case-mix of trainees	• Summary statistics of number and case-mix of surgical cases managed by the OMS in the previous year. • Annual logbook summary for each trainee for the previous and current year. • Feedback from trainees and supervisors.	• Regular elective and acute admissions. • Evidence trainees are being given professional responsibility under supervision, to their level of training and experience. • Evidence trainee caseload and mix is facilitated with a focus on competence acquisition.	

		• There are no gross deficiencies in any area of the curriculum.	
2.5 Operative experience of the trainee	• Documentation on weekly theatre schedule.	• A minimum of two (2) consultant supervised, dedicated theatre sessions per week per trainee *or* the equivalent of eight (8) half day theatre sessions per month. • Evidence operative scheduling focuses on opportunities for trainees to gain the competencies and is based on a combination of theatre time, case numbers and case mix. • No conflicting work requirements.	
2.6 Experience in perioperative care	• Clinical examination rooms available.	• Evidence adequate rooms are available to enable appropriate clinical examination of all pre- and post-operative patients.	
2.7 Access to day-care/minor surgery	• Documentation on access to day surgery and minor surgery lists.	• Trainees have regular weekly experience with day surgery and minor surgical procedures.	
2.8 Involvement in the acute/emergency care of surgical patients	• Documentation showing frequency of involvement in acute/emergency care of surgical patients. • Provision of on call roster. • Evidence of trainees' exposure to emergency operative surgery.	• Regular involvement in acute/emergency care of surgical patients. • Rosters and work scheduled enable trainee to participate in emergency surgery.	

Standard 3 – Equipment and Support Services **Facilities, equipment and clinical support must enable trainees' exposure to deliver patient care across the range of required clinical experience.**			
Accreditation Criteria	**Assessed by**	**Minimum Requirements**	**Standard MET, UNMET or MET WITH EXCEPTION**
3.1 Facilities and equipment available to carry out surgery	• Hospital has accredited status to undertake surgery.	• Evidence of accreditation by ACHS (Australia) or HealthCERT (New Zealand) to undertake surgical care.	
3.2 Imaging – diagnostic and intervention services	• Documentation on accreditation.	• Accredited by appropriate body/ agency.	

Standard 4 – Resources to support education and training **Trainees must have access to educational facilities/resources required to deliver the curriculum.**			
Accreditation Criteria	**Assessed by**	**Minimum Requirements**	**Standard MET, UNMET or MET WITH EXCEPTION**
4.1 Medical Library services and access	• Access to library and required learning resources. • Feedback from trainees and supervisors.	• Library available with core textbooks and journals either in hard copy or online.	
4.2 Computer facilities with IT support	• Computer facilities with internet access.	• Computers available and accessible 24 hours /day, with free internet access.	
4.3 Tutorial room available	• Documented booking and access processes. • Feedback from supervisor and trainees.	• Tutorial rooms available when required.	
4.4 Access to private study area	• Designated study area. • Feedback from trainees.	• Designated study room/area available and isolated from busy clinical area.	

Standard 5 – Supervision **Effective supervision must be provided to support trainees in acquiring the necessary education, skills and experience.**			
Accreditation Criteria	**Assessed by**	**Minimum Requirements**	**Standard MET, UNMET or MET WITH EXCEPTION**
5.1 Assigned Director of Training (per network/ Training Centre)	• Documentation on Director of Training. • Participation in relevant college meetings and regional surgical committee meetings.	• Assigned Director of Training holds FRACDS(OMS) or equivalent. • Assigned Director of Training is actively involved in OMS training and participates in college meetings and courses. • Assigned Director of Training is a member of the relevant regional surgical committee.	
5.2 Head of department	• Relevant hospital/ unit documentation.	• Registered Specialist FRACDS(OMS) or equivalent or FRACS.	
5.3 Designated Supervisor of Training (per training post)	• Documentation on Supervisor of Training. • Feedback from trainees. • Attendance at regional surgical committee meetings and college meetings where relevant.	• Supervisors of Training hold FRACDS(OMS) or equivalent. • Each trainee has a clearly identifiable Supervisor of Training. • Evidence Supervisors of Training are regularly available and accessible to assigned trainees. • Supervisors of training have a minimum of two (2) sessions per week with each assigned trainee. *or* the equivalent of eight (8) sessions with each assigned	

		trainee per month. • Supervisors of Training are actively involved in OMS training and participate in college meetings and courses. • Two (2) or more Supervisors of Training are assigned with four (4) or more trainees.	
5.4 Specialist surgical staff appropriately qualified to carry out surgical training	• Documentation on qualifications of specialist surgical staff. • College representative included on interview panel for the appointment of new staff.	• Surgeons have FRACDS(OMS) or FRCS or equivalent.	
5.5 Regular supervision, assessment, and feedback to trainees	• Documentation on hospital/dept practices relating to supervision, assessment and feedback to trainees. • Feedback from trainees. • College assessment and supervision documentation.	• Initial meeting between Supervisor of Training and trainee at the commencement of each rotation – goals discussed. • Evidence of one-to-one regular supervision. • Regular constructive feedback on performance. • Evidence there is opportunities for trainees to rectify weaknesses. • Three-monthly progress reviews occurring with Supervisor of Training and trainee. • One to one discussion on six-monthly formative assessment occurring between Supervisor of Training and trainee.	

Standard 6 – Organisational Support for Trainees **Institutions must support the OMS training program by demonstrating a culture that supports a commitment to education, training, learning and wellbeing of trainees.**			
Accreditation Criteria	**Assessed by**	**Minimum Requirements**	**Standard MET, UNMET or MET WITH EXCEPTION**
6.1 Hospital support for trainees	• Safe working hours and appropriate on on-call scheduling. • Hospital safety procedures for trainees working outside of normal working hours. • Trainee access to Human Resources. • Trainee and supervisor feedback.	• Rosters and work schedules are in line with the Australian Medical Association (AMA) National Code of Practice, Hours of Work, Shift Work, and Rostering for Hospital Doctors. *or* In New Zealand, rosters and work schedules consider the principles outlined in the Multi-Employer Collective Agreement (MECA). • Recognition of safety and provision of security when necessary. • Readily accessible Human Resources service available to trainees including counselling if required.	
6.2 Appropriate hospital/ unit orientation for new trainees	• Documentation on Hospital induction plan/ process. • Feedback from trainees.	• New trainees attend orientation meeting to acquaint them with the hospital and department practices.	

Standard 7 – Institutional Responsibilities **The institution fosters commitment to the OMS training program and the availability of skilled senior medical staff as supervisors.**			
Accreditation Criteria	**Assessed by**	**Minimum Requirements**	**Standard MET, UNMET or MET WITH EXCEPTION**
7.1 Supervisor's role and responsibilities	• Hospital documentation on supervisor's role in keeping with college requirements. • HR Policy on educational leave.	• Supervisor role complies with College requirements. • Negotiated leave for attendance at OMS meetings/courses.	
7.2 Flexible training options are available for trainees	• HR policy on part-time and job-sharing options. • Trainee feedback.	• Evidence of flexible employment policy allowing for part-time and job-sharing options. • Clearly identified processes for applying for flexible employment.	
7.3 Hospital support for surgeons involved in training	• Documentation on weekly service and educational activities of staff. • HR policy on educational leave. • Feedback from surgeons.	• Negotiated time for supervision/teaching. • Negotiated leave for surgeons/trainers who attend RACDS courses/meetings.	

Standard 8 – Quality and Safety **The training environment must be supported by a governance structure to deliver and monitor safe practices.**			
Accreditation Criteria	**Assessed by**	**Minimum Requirements**	**Standard MET, UNMET or MET WITH EXCEPTION**
8.1 Hospital accreditation status	• Evidence of accreditation.	• Hospital accredited by ACHS (Australia) *or* HealthCERT (New Zealand).	
8.2 Risk management processes with patient safety and quality committee reporting to Quality Assurance Board	• Documentation on processes including those for correct site surgery.	• Quality Assurance Board or equivalent reporting to appropriate governance body. • Documentation published by Human Resources, clinical risk management and other safety policies.	
8.3 Head of OMS Department and governance role	• Documentation on structure of surgical department. • Position description and reporting lines of OMS service. • Records of Surgical Department meetings.	• Head of OMS is a recognised position in the hospital surgical committee. • If the Head of OMS department is, is not an FRACDS(OMS) or equivalent, an OMS Consultant be in attendance by invitation at surgical committee meetings.	
8.4 Hospital credentialing or privileging committee	• Documentation on credentialing or privileging committee and its activities.	• Clinicians credentialed every five years.	
8.5 Surgical audit and peer review program	• Documentation on audit and peer review program for unit.	• Six Monthly audit review of morbidity/mortality • All surgical staff participate. • Opportunity for trainees to participate.	

8.6 Hospital systems reviews	• Documentation on systems reviews.	• Surgeons and trainees participate in review of patient/system adverse events.	
8.7 Occupational safety	• Evidence of education on protection against ionising radiation and/or Laser to patients and staff. • Documentation on hospital protocol relating to accidental infection of staff i.e., needle stick injury etc. (Infection Control).	• Provision of education on protection. • Radiation protective equipment available. • Clear protocol for infection control.	

Standard 9 – Promoting an environment of culture and respect for staff and patients. **The institution demonstrates and promotes a culture of respect for patients and staff, improving patient and staff safety.**			
Accreditation Criteria	**Assessed by**	**Minimum Requirements**	**Standard MET, UNMET or MET WITH EXCEPTION**
9.1 Hospital fosters a culture of respect and professionalism	• Trainee and supervisor feedback. • Hospital has policies and procedures on building and maintaining an environment of culture and respect, including training for all staff.	• Hospital supports a safe training environment free of discrimination, bullying and sexual harassment. • Hospital promotes respect, including teamwork principles.	
9.2 Hospital complaint management process	• Hospital has policies and procedures for the open and transparent management and investigation of complaints of discrimination, bullying, and sexual harassment.	• Clearly defined process to handling complaints and protecting complainants. • Appropriate Human Resource processes are in place to document performance reviews, misdemeanors, and serious complaints.	
9.3 Hospital response to feedback conveyed by RACDS on behalf of trainees	• Mechanisms for dealing with feedback.	• Resolution of validated problems.	

Standard 10 – Cultural competency and safety **The institution demonstrates commitment to promoting Aboriginal and Torres Strait Islander or Māori cultural competence.**			
Accreditation Criteria	**Assessed by**	**Minimum Requirements**	**Standard MET, UNMET or MET WITH EXCEPTION**
10.1 Hospital promotes cultural safety training.	• Hospital has policies or procedures that ensure supervisors and trainees in the OMS unit are given the time to complete cultural safety training and other educational activities that promote and enhance cultural competence in the workplace.	• Hospital provides educational activities relating to cultural competence and Indigenous health.	
10.2 Hospital and OMS unit create a safe and inclusive environment that provides culturally appropriate care.	• Hospital has policies or procedures that promote a healthcare service that is equitable, accessible and responsive to the socially, culturally, and linguistically diverse community it serves. • Hospital and OMS unit have an induction program, including orientation to relevant cultural safety training and policies on delivering culturally appropriate care.	• Hospital promotes a healthcare service that is equitable, accessible, and responsive to the socially, culturally, and linguistically diverse community it serves. • Hospital and OMS unit orient supervisors and trainees on cultural safety and competency training for patient care, hospital processes to improve the delivery of Indigenous health and Treaty of Waitangi training in Aotearoa New Zealand.	

Appendix 1

PRE-ACCREDITATION VISIT SURVEY FOR ORAL AND MAXILLOFACIAL SURGERY TRAINING POST	FOMS 18

Instructions

This form relates to applications for the accreditation of all new and existing OMS training posts, in accordance with the RACDS Standards and Criteria for Oral and Maxillofacial Surgery (SCOMS).

Please refer to the *RACDS Standards and Criteria for Accreditation of Regional Training Centres, Hospitals and Posts* for further information.

Please choose one of the following:

☐ Application for accreditation for additional or a new post

☐ Application for accreditation of existing post/s

Post Title		**Date of Application**	
Post Address (Hospital site/ Institutions where training occurs)		**Current number of accredited posts**	
Training Centre		**Current number of accredited posts in Training Centre**	
Supervisor of Training		**Director of Training**	

PART 1 – SUPERVISOR OF TRAINING TO COMPLETE							
Training Post Information – Supervision & Hospital Structure							
Head of Department/ Unit							
Chief of Surgery							
Supervisors of Training	**Full Name**		**Post FTE**		**Number of operating lists per month**		**Number of clinics per week**
Consultant Trainers	**Full Name**		**Post FTE**		**Number of operating lists per month**		**Number of clinics per week**
Number of Theatres			**Number of Beds**				
Is OMS a standalone department or headed by ENT/PRS?	☐ **Yes**		☐ **No**		**Department headed by:**		
Number of Registered Nurses in unit			**Number of Dental Assistants in unit**				

Current OMS Trainees	Full Name	Year of Training	FTE

Standard 1: Education and Training			
Accreditation Criteria	**Documentation Requested**	**Comments / Response**	**Supporting attachment reference (If applicable)**
1.1 Co-ordinated schedule of learning experiences for each trainee	Trainee's/registrar's weekly timetable. **In units with more than one trainee/registrar – please attach individual trainee/registrar timetables.* The frequency and nature of coordinated learning experiences. E.g., Audits, journal clubs, tutorials.		
1.2 Clinical Training Assessment	Individual trainee portfolio's to be available for checking at time of visit.		
1.3 Access to external educational activities for trainees	Institutions HR Policy on educational leave for trainees/registrars.		
1.4 Opportunities for research	Please attach the five (5) most recent publications from the training unit.		

Standard 2: Clinical Experience			
Accreditation Criteria	**Documentation Requested**	**Comments / Response**	**Supporting attachment reference (If applicable)**
2.1 Supervised consultant outpatient clinics	Scheduling documenting frequency of consultative clinics. Documentation showing trainees/registrars see new patients and follow up / review patients.		
2.2 Beds available for OMS	Documentation on accessible beds for OMS.		
2.3 Consultant led ward rounds with educational and clinical goals	Scheduling documenting frequency of consultant led ward rounds.		
2.4 Caseload and case-mix of trainees	Summary statistics of number and case-mix of surgical cases managed by the OMS in the previous year. Annual logbook summary for each trainee/ registrar occupying post for the previous and current year.		
2.5 Operative experience of the trainee	Weekly theatre schedules. **In units with more than one trainee/registrar – please attach all relevant schedules.*		
2.6 Experience in peri- operative care	Are there clinical examination rooms available for use?		

2.7 Access to day care/minor surgery	Is there regular access to day care/minor surgery lists?		
2.8 Involvement in the acute/emergency care of surgical patients	On-call roster. Documentation showing frequency of involvement in acute/emergency care of surgical patients.		

Summary statistics of number and casemix of surgical cases managed by OMS in the previous year			
Scope of practice	**Full or limited scope?**	**Shared with other service?**	**Number of cases in the last 12 months**
Dentoalveolar			
Oral and facial infection			
Facial trauma			
Pathology – benign and malignant)			
Preprosthetic and adjunctive implant procedures			
Implants			
Orthognathic – single jaw			
Orthognathic – bimaxillary			
Orthognathic – other			
TMJ			
Maxillary sinus			
Trauma			
Reconstructive – hard tissue			
Reconstructive – soft tissue and composite			
Reconstructive – graft harvest			
Other procedures			

Standard 3: Equipment and Support Services			
Accreditation Criteria	**Documentation Requested**	**Comments / Response**	**Supporting attachment reference (If applicable)**
3.1 Facilities and equipment available to carry out surgery	Evidence of accreditation by ACHS (Australia) or HealthCERT (New Zealand).		
3.2 Imaging – diagnostic and intervention services	Summary of services available		
Standard 4: Resources to Support Education and Training			
Accreditation Criteria	**Documentation Requested**	**Comments / Response**	**Supporting attachment reference (If applicable)**
4.1 Medical Library services and access	Please provide the name and location of the library. Do trainees/registrars have after- hours access to the library?		
4.2 Computer facilities with IT support	Computers available with free internet access. 24-hour computer access acknowledging security issues.		
4.3 Tutorial room available	Tutorial rooms available when required.		
4.4 Access to private study area	Designated study room/area available isolated from busy clinical areas.		

Standard 5: Supervision			
Accreditation Criteria	**Documentation Requested**	**Comments / Response**	**Supporting attachment reference (If applicable)**
5.4 Specialist surgical staff appropriately qualified to carry out surgical training	OMS unit organisational chart which includes specialist surgical staff qualifications.		
5.5 Regular supervision, assessment, and feedback to trainees	Documentation on institution/dept practices relating to supervision, assessment, and feedback to trainees.		

PART 2 – INSTITUTION TO COMPLETE			
Standard 6: Organisational Support for Trainees/ Registrars			
Accreditation Criteria	**Documentation Requested**	**Comments / Response**	**Supporting attachment reference (If applicable)**
6.1 Hospital support for trainees	Policy on safe working hours and appropriate on-call scheduling. Summary of Institutions safety procedures for trainees working outside of normal working hours. A copy of the award under which the trainee/registrar is paid, and safe working hours are determined.		
6.2 Appropriate hospital/ unit orientation for new trainees	Documentation on Hospital induction plan/ process.		
Standard 7: Institutional Responsibilities			
Accreditation Criteria	**Documentation Requested**	**Comments / Response**	**Supporting attachment reference (If applicable)**
7.1 Supervisor's Role and Responsibilities	Hospital documentation on supervisor's role in keeping with college requirements. HR Policy on educational leave.		
7.2 Flexible training options are available for trainees	Institutions HR policy on part-time and job-sharing options.		

7.3 Hospital support for surgeons involved in training	Documentation on weekly service and educational activities of staff. HR policy on educational leave.		
Standard 8: Quality and Safety			
Accreditation Criteria	**Documentation Requested**	**Comments / Response**	**Supporting attachment reference (If applicable)**
8.1 Hospital accreditation status	Evidence of hospital accreditation (minimum requirement accredited by ACHS (Australia) or HealthCERT (New Zealand).		
8.2 Risk management processes with patient safety and quality committee reporting to Quality Assurance Board	Documentation on processes including those for correct site surgery. Documentation on Quality Assurance Board or equivalent reporting to appropriate governance body. e.g., Documentation published by HR, clinical risk management and other safety policies		
8.3 Head of OMS Department and governance role	Documentation on structure of surgical department. Position description and reporting lines of OMS service.		
8.4 Hospital credentialing or privileging committee	Documentation on credentialing or privileging committee and its activities.		
8.5 Surgical audit and peer review program	Documentation on audit and peer review program for unit.		

8.6 Hospital systems reviews	Documentation on systems reviews.		
8.7 Occupational safety	Evidence of education on protection against ionising radiation and/or laser to patients and staff. Documentation on hospital protocol relating to accidental infection of staff i.e. needle stick injury etc. (e.g. Infection Control).		
Standard 9: Promoting an environment of culture and respect for staff and patients			
Accreditation Criteria	**Documentation Requested**	**Comments / Response**	**Supporting attachment reference (If applicable)**
9.1 Hospital fosters a culture of respect and professionalism	Institutions policies and procedures on building and maintaining an environment of culture and respect, including training for all staff.		
9.2 Hospital complaint management process	Institutions policies and procedures for the open and transparent management and investigation of complaints of discrimination, bullying, and sexual harassment.		

Standard 10: Cultural competency and safety			
Accreditation Criteria	**Documentation Requested**	**Comments / Response**	**Supporting attachment reference (If applicable)**
10.1 Hospital promotes cultural safety training	Institutions policies or procedures that ensure supervisors and trainees in the OMS unit are given the time to complete cultural safety training and other educational activities that promote and enhance cultural competence in the workplace.		
10.2 Hospital and OMS unit create a safe and inclusive environment that provides culturally appropriate care	Institutions policies or procedures that promote a healthcare service that is equitable, accessible and responsive to the socially, culturally, and linguistically diverse community it serves. Documentation of the induction program, including orientation to relevant cultural safety training and policies on delivering culturally appropriate care.		