AN ACCREDITATION SYSTEM
FOR RURAL GENERALIST EDUCATION PROGRAMS
FOR THE ALLIED HEALTH PROFESSIONS
Consultation paper released 6 April 2018

CONSULTATION FEEDBACK DUE 30 APRIL 2018
Feedback is sought on three components of the accreditation system:
1. Competency Framework
2. Accreditation Standards
3. Accreditation Procedures

Consultation questions are posed within this paper. Please submit feedback using the submission template to Kylie Woolcock at kwoolcock@ahha.asn.au
OUR VISION
A healthy Australia, supported by the best possible healthcare system.

OUR MISSION
To conduct research, educate and influence the healthcare system to achieve better health outcomes, improved patient and provider experience, greater equity and sustainability.

OUR GUIDING PRINCIPLES
Healthcare in Australia should be:
- Effective
- Accessible
- Equitable
- Sustainable
- Outcomes-focused.

OUR CONTACT DETAILS
Australian Healthcare and Hospitals Association
Unit 8, 2 Phipps Close
Deakin ACT 2600
PO Box 78
Deakin West ACT 2600
P. 02 6162 0780
F. 02 6162 0779
E. admin@ahha.asn.au
W. ahha.asn.au

facebook.com/AusHealthcare
@AusHealthcare

linkedin.com/company/australian-healthcare-&-hospitals-association
ABN. 49 008 528 470

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TABLE OF CONTENTS

Introduction .................................................................................................................. 2

What is a rural generalist in the allied health professions? ........................................... 2
Advancing rural generalist practice in the allied health professions ............................ 2

The accreditation system .............................................................................................. 4

Scope of the accreditation system .............................................................................. 4
Rationale for the accreditation system .......................................................................... 4
Resources to support development of the accreditation system ................................. 5
New resources for stakeholder consultation ............................................................... 6

Background to Resource 1: Competency Framework ............................................... 8

competency Framework model ..................................................................................... 8
Using the Competency Framework and Education Framework in accreditation .......... 9
Consultation questions for Resource 1 .......................................................................... 9

Background to Resource 2: Accreditation Standards ............................................. 10

The Accreditation Standards model ........................................................................... 10
Consultation questions for Resource 2 ......................................................................... 12

Background to Resource 3: Accreditation procedures ........................................... 13

Consultation questions for Resource 3 ....................................................................... 13

Summary of consultation questions .......................................................................... 17

References ..................................................................................................................... 19

APPENDIX 1. Draft Resource 1: Competency Framework ................................. 20

APPENDIX 2. Draft Resource 2: Accreditation Standards ............................. 31
INTRODUCTION

An accreditation system for rural generalist education and training for seven allied health professions in Australia is being developed.

WHAT IS A RURAL GENERALIST IN THE ALLIED HEALTH PROFESSIONS?

The term ‘rural generalist’ refers to an allied health professional that responds to the broad range of healthcare needs of a rural or remote community. These practitioners require a broad skill-set and a strong reliance on teamwork, multi-disciplinary and inter-professional practice and the development of innovative service delivery models. Services are delivered for a wide breadth of clinical presentations and to people across the age spectrum, and usually in a variety of healthcare delivery settings e.g. inpatient, ambulatory care, community (SARAH 2017).

Rural generalists have a primary health professional qualification. They practice under the regulatory instruments relevant to the individual’s specific allied health profession and the policies of their employer (SARAH 2017).

Health services have increasingly recognised that rural generalism can be considered an area of practice with a skill set that can be defined. This skill set includes clinical and non-clinical capabilities that, although not unique to rural and remote practice, are important for these settings. The skill set is strongly influenced by the context of rural and remote practice with the ability to design and deliver accessible, effective, efficient and acceptable services to geographically dispersed populations as part of small multi-disciplinary and inter-agency teams being the hallmark of a good rural generalist practitioner.

ADVANCING RURAL GENERALIST PRACTICE IN THE ALLIED HEALTH PROFESSIONS

The accreditation system being developed is one component of an emerging national Allied Health Rural Generalist (AHRG) Pathway.

The AHRG concept has been advancing since 2013 and involves a cross-jurisdictional approach being pursued through a collaboration that includes state and territory health services from across Australia and led by Services for Australian Rural and Remote Allied Health (SARAH).

Work on an AHRG Pathway has been driven by the recognition of poorer access to health services in rural and remote communities when compared with metropolitan areas, despite the disproportionate burden of illness, and acknowledges the broad range of factors contributing to service access limitations, including maldistribution of the health workforce, reduced variety and fewer specialist services, and difficulties recruiting and retaining staff.

The AHRG Pathway includes:

- **Workforce/employment structures** that support recruitment and retention, and facilitate progress from graduate level through to a proficient rural generalist in the relevant allied health profession and into extended scope of practice, where required and supported by the health service;
An accreditation system for rural generalist education programs for the allied health professions

- **Education and training**, supporting the development of skills and capabilities of the allied health professional in order to meet the challenges of delivering services in rural and remote areas; and
- **Service delivery strategies and models** that ensure equitable access to high quality multi-disciplinary services for rural and remote communities (SARRAH 2017).

This work focuses on the area of education and training, recognising there is additional work occurring in parallel relating to the other areas of the Pathway.


For resources to support implementation of AHRG positions in your service, please visit [https://www.sarrah.org.au/ahrgp](https://www.sarrah.org.au/ahrgp)
THE ACCREDITATION SYSTEM

SCOPE OF THE ACCREDITATION SYSTEM

The seven professions included in the current scope of the AHRG Pathway are: nutrition and dietetics, occupational therapy, pharmacy, physiotherapy, podiatry, radiography and speech pathology.

The scope of the accreditation system is for these seven professions in relation to their role in providing care in a health service setting in rural and remote areas. This care may be delivered in state/territory health services, the non-government sector or the private sector.

The scope does not currently include other allied health professions or other service settings (e.g. disability, social services, health promotion or public health). However, it is acknowledged that there are allied health professionals providing services in these other sectors in rural and remote areas. There may be future opportunities to examine expanding the focus of the AHRG Pathway, but other professions and sectors are not in scope of this project.

The AHRG Pathway has been designed to support the workforce that possess a primary qualification in one of the seven nominated professions. That is, entry-level education and competencies are not in scope of this work. The scope of the accreditation system project will only apply to post-graduate education.

RATIONALE FOR THE ACCREDITATION SYSTEM

Health service partners involved in developing the AHRG Pathway have identified the need to have a benchmark for rural generalist education and training programs. A common understanding of the capabilities and competencies developed in rural generalist education and training programs is required to allow health services to integrate the qualification into industrial instruments, employment models and business/commissioning processes. Accreditation standards for rural generalist education programs will provide quality assurance for health services, commissioning agencies and for potential participants that the program meets the published standards, and by extension that a graduate of an accredited program possesses the competencies described in the standards.

For allied health professionals with a passion for rural and remote practice, accreditation will support selection of an education program that will meet their development requirements. An accredited program may also support engagement with employers and commissioning/service purchasing agencies by providing an indicator of proficiency in rural generalist practice.

Accreditation will also support tertiary education providers to develop rural generalist programs that meet health sector requirements and funding schemes for trainees. The standards will assist education providers to map existing post-graduate offerings and identify opportunities to target gaps through developing education offerings or forming relationships with other institutions. The objective for health sector stakeholders is to facilitate the development of programs that meet industry and student requirements.
An accreditation system for rural generalist education programs for the allied health professions

A substantial component of the rural generalist education program is not profession-specific including service development, education and training, cross-cultural service delivery, rural and remote health context and service delivery strategies. As these components do not fall under the governance of a single profession, an independent process of describing and monitoring these standards is required, which can be managed through an accreditation body and standards.

RESOURCES TO SUPPORT DEVELOPMENT OF THE ACCREDITATION SYSTEM

The Australian Healthcare and Hospitals Association (AHHA) has been engaged by Queensland Health to develop the accreditation system for rural generalist education and training for the seven allied health professions.

A key resource underpinning development of the accreditation system is the Allied Health Rural Generalist Education Framework. The Education Framework was developed in 2015–16 through a two-stage project sponsored by Queensland Health and managed by the Cunningham Centre, Darling Downs Hospital and Health Service and the Greater Northern Australia Regional Training Network. It describes the development requirements of rural generalists for seven allied health professions. The frame of reference is the service need, i.e. what the health service/team needs to do to deliver a rural generalist service that addresses demand and health needs of the community, rather than the training of an individual health professional in isolation from their work role.

The Education Framework reflects the continuum from commencing independent practice in the individual’s profession through to becoming a proficient rural generalist, and into extended scope and complex practices where this is required by the local service. (See Figure 1)

Figure 1. Allied Health Rural Generalist Pathway

<table>
<thead>
<tr>
<th>Level 1 training stage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Role</strong></td>
</tr>
<tr>
<td>Early career role (0-3 year)</td>
</tr>
<tr>
<td><strong>Support / supervision</strong></td>
</tr>
<tr>
<td>Co-located, profession-specific supervisor</td>
</tr>
<tr>
<td><strong>Education &amp; training</strong></td>
</tr>
<tr>
<td>Level 1 Rural Generalist Program</td>
</tr>
<tr>
<td>Intensive workplace support</td>
</tr>
<tr>
<td>0.1 – 0.2 FTE allocated time</td>
</tr>
<tr>
<td><strong>Service</strong></td>
</tr>
<tr>
<td>Use and/or support development of rural generalist service delivery strategies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 2 training stage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Role</strong></td>
</tr>
<tr>
<td>&gt;2 years professional experience</td>
</tr>
<tr>
<td>Greater independence in complex decision-making</td>
</tr>
<tr>
<td>Increasing clinical leadership</td>
</tr>
<tr>
<td><strong>Support / supervision</strong></td>
</tr>
<tr>
<td>Professional, inter-professional, onsite or ‘remote’</td>
</tr>
<tr>
<td><strong>Education &amp; training</strong></td>
</tr>
<tr>
<td>Level 2 Rural Generalist Program</td>
</tr>
<tr>
<td>Increasing individual responsibility</td>
</tr>
<tr>
<td>~0.1 FTE allocated time</td>
</tr>
<tr>
<td><strong>Service</strong></td>
</tr>
<tr>
<td>Increasing integration in practice and leadership of rural generalist service delivery strategies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proficient Rural Generalist</th>
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<tbody>
<tr>
<td><strong>Role</strong></td>
</tr>
<tr>
<td>‘Proficient Rural Generalist’ scope with clinical leadership in the service and may integrate</td>
</tr>
<tr>
<td>- extended scope</td>
</tr>
<tr>
<td>- complex practice</td>
</tr>
<tr>
<td><strong>Support / supervision</strong></td>
</tr>
<tr>
<td>Mentoring for leadership skills</td>
</tr>
<tr>
<td>Practice supervision (ext scope)</td>
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<tr>
<td>Supervise RG trainees</td>
</tr>
<tr>
<td><strong>Education &amp; training</strong></td>
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<tr>
<td>Extended scope / complex practice training programs</td>
</tr>
<tr>
<td>Leadership and management</td>
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<tr>
<td>Education and research</td>
</tr>
<tr>
<td>Dual responsibility of individual and employer</td>
</tr>
<tr>
<td><strong>Service</strong></td>
</tr>
<tr>
<td>Clinical leadership of rural generalist service delivery</td>
</tr>
</tbody>
</table>
The Education Framework drew on a range of information sources including (AHPOQ 2018):

- **Stage 1 of the AHRG Pathway strategy:**
  A comprehensive mapping of clinical tasks and functions for six professions across five rural and remote services (public and community-controlled) in three jurisdictions. This resulted in a detailed description of rural generalist clinical requirements, including identification of profession-specific clinical tasks and tasks potentially appropriate for skill sharing between professions or delegation to support workers, where training, supervision and governance processes were available in the team (GNARTN 2013).

- **Stage 2 of the AHRG Pathway strategy:**
  A stakeholder review and validation of the skill-shared tasks identified in Stage 1.

- **Stage 3 of the AHRG Pathway strategy:**
  A trial of designated early career (Level 1) rural generalist AHRG training positions in Queensland hospital and health services. One finding from the evaluation conducted by Southern Cross University was that the lack of formal rural generalist education programs was a key barrier to progressing the AHRG concept (Nancarrow et al. 2015)

- **Extensive consultation with rural and remote allied health professionals and professional leaders in Queensland and interstate (SARRAH 2017)**

- **Review of documents relevant to rural and remote practice for the seven professions including the WACHS allied health competency frameworks, Queensland Health HP3-HP4 Rural Development Pathway, HealthLEADS, profession-specific standards/frameworks and published literature.**

Following drafting of the Allied Health Rural Generalist Education Framework in 2015, GNARTN oversaw an expert review. Finalisation of the document was undertaken by Kristine Battye Consulting in 2016. Reviewers included senior academics from Australia and New Zealand in each of the seven professions. Feedback was integrated into the Education Framework, which were provided under a one-year exclusive license period to James Cook University. This university, working in partnership with QUT was contracted in late 2016 by Queensland Health to develop a formal, two-level rural generalist training program to support the multi-jurisdictional trial of rural generalist training positions 2017–19.


**NEW RESOURCES FOR STAKEHOLDER CONSULTATION**

In the development of the accreditation system, the following resources are being developed:

1. Competency framework
2. Accreditation standards
3. Accreditation system implementation resources, including governance and operational/procedural documents and communication tools.

Background to the development of these resources is provided in the following sections to support stakeholder review and feedback.
An accreditation system for rural generalist education programs for the allied health professions

The value of these resources will rest with their capacity to support and facilitate professional practice and growth in rural generalism for the allied health professions. However, it must be remembered that the role has been developed from the perspective of health service need, supporting rural and remote communities to improve health outcomes through increasing access to multi-professional team-based health care. A strong link to practical rural generalist service requirements should be retained in all derivative products.
BACKGROUND TO RESOURCE 1: COMPETENCY FRAMEWORK

COMPETENCY FRAMEWORK MODEL

Competency standards are an important basis by which professions in Australia define the attributes of the competent practitioner. Competency frameworks (or equivalent) exist for each of the seven allied health professions involved in the scope of this work, describing the knowledge, skills and other attributes that are to be attained for entry to the profession.

The Competency Framework for rural generalists in the allied health professions has been developed based on the modified Dreyfus model (Khan & Ramachandran 2012), a current model for explaining the relationship between competence and performance. This model identifies seven levels of performance along a continuum (see Figure 2).

Figure 2. Curve of improving performance adapted for health care – modified from Dreyfus and Dreyfus (1980) and ten Cate et al (2010) (Khan & Ramachandran 2012)

In this model, individuals move along the curve of improving performance through a combination of training and deliberate practice.

The Competency Framework for rural generalists in the allied health professions is based on the assumption that competence, as defined in profession-specific standards, has been achieved at the point of entering a profession, and is one point on a curve of improving performance.

The Competency Framework describes the performance expected of an individual practising as a rural generalist in their profession. Performance is described at two levels: Level 1 and Level 2, reflecting the progression of an individual in the AHRG Pathway after achieving competence in their chosen profession (see Figure 1). It reflects the integration of the knowledge, skills and attitudes attained, i.e. the outcome of education and experience, as the individual enters the transition to the next level in the Pathway, with performance at Level 1 assumed for those at Level 2. A ‘Level 3’ is also identified in the AHRG Pathway in Figure 1, reflecting the scope of a ‘Proficient Rural Generalist’ in the individual’s profession. Performance in Level 3 is not defined in this Competency Framework.

The AHRG Competency Framework has been developed from the AHRG Education Framework.
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USING THE COMPETENCY FRAMEWORK AND EDUCATION FRAMEWORK IN ACCREDITATION

In accreditation, in Australia and internationally, there is a continuing emphasis on outcome-based standards, partly from recognition that prescriptive input standards such as curriculum inhibit innovation.

However, it is also well-recognised that both input and outcome-based standards are necessary for assessment and accreditation of an education program. A purely input-based accreditation cannot provide confidence that graduates have achieved the desired competencies, while a purely output-based approach will provide no hint of where to look for improvement when graduate performance varies (HPAC Forum 2017).

With defined rural generalist training roles for the allied health professions being relatively new in Australia, education providers developing programs will see a greater emphasis initially on inputs in the accreditation process. It is expected that the Competency Framework forms a core part of an outcome-focused approach to accreditation. However, at least initially, education programs will be expected to be developed with strong reference to the specifications in the Education Framework, which describes the service and practice requirements of rural generalists at the conclusion of education (i.e. more input-based).

Over time, as familiarity with the AHRG concept increases, the emphasis in accreditation on education programs meeting the performance requirements defined in the Competency Framework, rather than the Education Framework, is expected to increase.

CONSULTATION QUESTIONS FOR RESOURCE 1

Resource 1: Competency Framework is provided as Appendix 1 (page 20) for stakeholder consultation.

1.1. Please identify any changes required. Please provide rationale for your recommendations wherever possible.

1.2. Please consider the profession-specific areas listed. With reference to the information in the Education Framework, what work needs to be done to ensure these clinical focus areas are well understood by all stakeholders?
BACKGROUND TO RESOURCE 2: ACCREDITATION STANDARDS

THE ACCREDITATION STANDARDS MODEL

In developing accreditation standards, current thinking includes that:

- **The focus is on professional competencies and learning outcomes**
  There should be a specific and detailed set of contemporary competency statements (ADC 2014a). The professional competencies and learning outcomes at graduation should be a focus (UA & PA 2016).

- **Accreditation standards are outcomes-focused**
  Adoption of outcome-based approaches for accreditation standards enables relevant and responsive health education programs (AHMAC 2017). Both education and health are highly dynamic environments. To enable innovation in the education of (and service delivery by) health practitioners, processes, methods and resources should be considered in terms of the outcomes and results achieved and functions fulfilled (HPAC 2016). However, it is recognised that a complete separation of process/structure and outcome in education program design and delivery is artificial, and may not be measurable in an accreditation system. As such both process/structure and outcome need to be considered (HPAC 2016).

- **Criteria for accreditation are evidence-based**
  Criteria are based on relevant Australian and international benchmarks and are demonstrably based on available research and evidence (UA & PA 2016) and robust peer review (ADC 2014a). There should be a rationalisation of evidence requirements to maximise benefit and minimise the burden on education providers, including considering information from other review processes as providing evidence towards meeting the accreditation standards (ADC 2014a).

- **The higher education environment is taken into account**
  Accreditation must be distinguished from the TEQSA monitoring of adherence to the Higher Education Standards Framework, and not duplicate effort or process (UA & PA 2016). There needs to be broad applicability across all education settings, not only universities (ADC 2014a).

- **There is flexibility in evidence requirements**
  Diverse institutional circumstances must also be accounted for (UA & PA 2016), with flexibility in evidence requirements to take account of the differences between Schools in their teaching and learning approaches and their clinical experience arrangements, as well as new and emerging educational trends (ADC 2014a).

- **Stakeholders are engaged in their development and review**
  Stakeholders include students, governments, education providers, industry, the profession and consumers/community (UA & PA 2016). They may be consulted through feedback mechanisms, workshops to discuss good practice and representation in accreditation committees, expert groups and policy development (HPAC 2016)

The development of an accreditation standards template based on common domains, for use across professions, was identified as a mechanism for improving efficiency in the accreditation process.
An accreditation system for rural generalist education programs for the allied health professions

(AHMAC 2017). In 2014, the ADC, in partnership with the Dental Council – New Zealand, developed a set of accreditation standards that could be used for a range of dental practitioners: dentists, dental specialists, dental hygienists and dental therapists, and dental prosthetists/clinical dental technicians. The Accreditation Standards include five Domains, with a descriptive Standard Statement (ADC 2014b).

Each of the dental practitioner groups has a separate set of competencies and professional attributes required of graduates. These are used as a key reference point in the accreditation process.

Since the release of the ADC Accreditation Standards, a number of other health professional accreditation agencies for entry-level allied health professional education programs have adopted this common set of Accreditation Standards through their own stakeholder review processes, albeit with some minor edits:

- Optometrists (OCANZ 2016)
- Chiropractors (CCEA 2017)
- Physiotherapists (APhysioC 2016)
- Psychologists (APAC 2017).

The Occupational Therapy Council (Australia and New Zealand) and three accreditation committees (Aboriginal and Torres Strait Islander Health Practice, Medical Radiation Practice, Chinese Medicine) are also considering options to commence with this format when next reviewing and updating their standards (AHMAC 2017).

The ADC template forms the basis for the draft Accreditation Standards for rural generalist education and training for the seven allied health professions. Amendments have been incorporated, primarily in recognition of rural generalist education relating solely to post-professional entry education programs, with students assumed to be subject to the regulatory instruments of their own profession (i.e. Domain 1).
CONSULTATION QUESTIONS FOR RESOURCE 2

Resource 2: Accreditation Standards is provided as Appendix 2 (page 31) for stakeholder consultation.

2.1 Please identify any other changes required. Please provide rationale for your recommendations.

2.2 Please provide comments about evidence expectations for meeting each of the standards.

Specifically:

2.3 Please consider the regulation of the higher education environment.
   - What overlap do you see? How do you recommend this be addressed?
   - What alignment in evidence requirements do you see? How do you recommend this be managed?

2.4 Please consider that students for these programs will have a primary health professional qualification and be practising under the regulatory instruments relevant to their specific allied health profession (unlike those for professions currently using the ADC standard template for entry-level programs).
   - How does this impact on the standards?
   - What evidence requirements need to be considered in relation to this?
BACKGROUND TO RESOURCE 3: ACCREDITATION PROCEDURES

Accreditation involves review and evaluation of various components of an education program against accreditation standards, such as the curriculum, resources, staffing, documentation and student management procedures.

The procedures used in the accreditation of education programs in Australia, particularly for those leading to an entry-level qualification in a regulated (registered/self-regulated) health profession, are fairly standardised. These processes will provide the benchmark by which processes are developed for the accreditation of education programs in rural generalist practice for allied health professions.

However, there are a number of factors that will differentiate this accreditation system from others, including that:

- seven allied health professions are currently included in the scope of the AHRG Pathway, contrasting it with the majority of other education accreditation processes that are profession-specific; and
- rural generalist education relates solely to post-professional entry education programs with students assumed to be subject to the regulatory instruments of their own profession.

CONSULTATION QUESTIONS FOR RESOURCE 3

[Note: there is no additional attachment relating to Resource 3.]

A simplified overview of a typical process for accreditation has been provided below, with questions aligned to different steps in the process to facilitate stakeholder feedback.

Please respond to these questions.
There is an increasing trend to commence accreditation assessments 18-24 months prior to the first intake of students, with the intent of awarding accreditation (with conditions) prior to marketing of the program or intake of students.

As the program develops and is delivered, the program is monitored, with the expectation that conditions will be removed with time. Such a process realises the benefits of an accrediting entity working closely with new programs as they develop, reducing the risk that students will enrol in a program that never achieves accreditation.

For education to effectively support the AHRG Pathway:

3.1. How early should the relationship between the accreditation entity and institution be established?

3.2. Should there be a requirement that an accreditation decision be made prior to accepting students?

3.3. What information about the program is important for the accreditation entity to review at the point an institution notifies them of their intent to develop a program?

Information used in the evaluation of programs can include a broad range of evidence such as documentation (e.g. curriculum mapped to Competency Framework with reference to Education Framework, staff CVs), observation of assessments, on-site review of facilities, and interviews with staff and students.

[It is recommended that stakeholders refer to the draft Competency Framework and draft Accreditation Standards when responding to the following questions.]

For education to effectively support the AHRG Pathway:

3.4. What expertise and experience are required by those evaluating a program? How should an evaluation team be composed to balance rigour and efficiency?

3.5. To what extent is profession-specific input to a program evaluation required? How should this be implemented?

3.6. What opportunities are there to align with existing team selection processes or training mechanisms? How might this work?

3.7. Are site evaluation visits necessary or can an evaluation of the program be done remotely (e.g. desktop review of documentation and internet-enabled interviews)? Please explain your response.
An accreditation system for rural generalist education programs for the allied health professions

**Action by accreditation entity:**

**Accreditation decision determined**
- Commonly, systems involve a program evaluation team reporting to an accreditation committee, who has delegated decision making power or makes a recommendation on a decision to the board of directors

**Action by accreditation entity:**
- Institution notified of accreditation decision for approval

**Action by institution:**

**Advertising to, and enrolment of, students**

**Action by institution:**

**Submission of annual progress reports**

**Action by accreditation entity:**

**Review annual progress reports**

**Action by institution:**

**Application for re-accreditation** of education program submitted:
- Continues similar to initial accreditation application

Independent accreditation is a concept considered best practice, referring to a framework where the accreditation system is autonomous and its quality assessment independent from government, the education providers and the professions. Market size may influence how this can be achieved.

For the accreditation system to provide independent assessments with the appropriate expertise in the accreditation process, while retaining a strong link to practical rural generalist service requirements and achieving an efficient process:

3.8. Will a typical accreditation decision-making structure (i.e. team→committee→board) be most appropriate for education to effectively support the AHRG Pathway? If not, what are the other considerations/recommendations?

3.9. If an accreditation committee is established, how should it be composed?

3.10. What opportunities are there to align with existing decision-making structures and processes? How might this work?

Annual reporting typically occurs through submission and review of annual progress reports. Reports typically cover responses against any conditions on accreditation and significant changes to the program (made or planned). Information may also be requested to support evaluation about pre-determined indicators of program quality or risk.

For education to effectively support the AHRG Pathway:

3.11. What recommendations do you have for indicators of program quality or risk that should be monitored for education to effectively support the AHRG Pathway?

There has been a shift in recent times with accreditation entities placing a greater emphasis on ongoing monitoring of programs rather than a set period of accreditation. This is considered to reduce the risk of programs failing to meet standards, allowing for earlier intervention, as well as ‘smoothing’ the administrative burden of accreditation over time for education providers.

For education to effectively support the AHRG Pathway:

3.12. What recommendations do you have for the emphasis being placed on ongoing monitoring rather than a set period of accreditation?
An accreditation system for rural generalist education programs for the allied health professions

It has been suggested that the accreditation system allow education providers to apply for accreditation of education offerings that meet specific standards within the Competency Framework, in addition to a more traditional accreditation process for a full program that meets all standards. For example, a university may have existing academic expertise and post-graduate offerings that can be leveraged to meet all inter-professional accreditation standards, and the profession-specific standards for pharmacy, physiotherapy, speech pathology and podiatry clinical practice, but not those of the remaining three professions.

**For education to effectively support the AHRG Pathway:**

3.13. Is it feasible to provide a mechanism for accreditation of a selection of standards within the Competency Framework? If so, is there a minimum level of program alignment to the standards that should be used as a threshold for an application for accreditation (e.g. minimum number of professions with a clinical training pathway in the program, any requirements to include both the inter-professional and clinical/profession-specific components in a single program)? What are the implications of this approach for different stakeholders? Are there alternative approaches that should be explored?

The opportunities and processes for initiation and management of grievances in relation to accreditation vary between accreditation systems, influenced by the systems’ role/purpose.

3.14. What mechanisms should be put in place for grievances in relation to accreditation of education supporting the AHRG Pathway?

3.15. Please provide any other feedback you have on the procedures for accreditation that are being developed.
SUMMARY OF CONSULTATION QUESTIONS

CONSULTATION QUESTIONS FOR RESOURCE 1: COMPETENCY FRAMEWORK

1.1. Please identify any changes required. Please provide rationale for your recommendations wherever possible.

1.2. Please consider the profession-specific areas listed. With reference to the information in the Education Framework, what work needs to be done to ensure these clinical focus areas are well understood by all stakeholders?

CONSULTATION QUESTIONS FOR RESOURCE 2: ACCREDITATION STANDARDS

2.1 Please identify any other changes required. Please provide rationale for your recommendations wherever possible.

2.2 Please provide any comments about evidence expectations for meeting each of the standards. Specifically:

2.3 Please consider the responsibilities of TEQSA accreditation vs professional accreditation.
   - What overlap do you see? How do you recommend this be addressed?
   - What alignment in evidence requirements do you see? How do you recommend this be managed?

2.4 Please consider that students for these programs will have a primary health professional qualification and be practising under the regulatory instruments relevant to their specific allied health profession (unlike those for professions currently using the ADC standard template for entry-level programs).
   - How does this impact on the standards?
   - What evidence requirements need to be considered in relation to this?

CONSULTATION QUESTIONS FOR RESOURCE 3: ACCREDITATION PROCEDURES

3.1. How early should the relationship between the accreditation entity and institution be established?

3.2. Should there be a requirement that an accreditation decision be made prior to accepting students?

3.3. What information about the program is important for the accreditation entity to review at the point an institution notifies them of their intent to develop a program?

3.4. What expertise and experience are required by those evaluating a program? How should an evaluation team be composed to balance rigour and efficiency?

3.5. To what extent is profession-specific input to a program evaluation required? How should this be implemented?

3.6. What opportunities are there to align with existing team selection processes or training mechanisms? How might this work?

3.7. Are site evaluation visits necessary or can an evaluation of the program be done remotely (e.g. desktop review of documentation and internet-enabled interviews)? Please explain your response.

3.8. Will a typical accreditation decision-making structure (i.e. team→committee→board) be most appropriate for education to effectively support the AHRG Pathway? If not, what are the other considerations/recommendations?
3.9. If an accreditation committee is established, how should it be composed?
3.10. What opportunities are there to align with existing decision-making structures and processes? How might this work?
3.11. What recommendations do you have for indicators of program quality or risk that should be monitored for education to effectively support the AHRG Pathway?
3.12. What recommendations do you have for the emphasis being placed on ongoing monitoring rather than a set period of accreditation?
3.13. Is it feasible to provide a mechanism for accreditation of a selection of standards within the Competency Framework? If so, is there a minimum level of program alignment to the standards that should be used as a threshold for an application for accreditation (e.g., minimum number of professions with a clinical training pathway in the program, any requirements to include both the inter-professional and clinical/profession-specific components in a single program)? What are the implications of this approach for different stakeholders? Are there alternative approaches that should be explored?
3.14. What mechanisms should be put in place for grievances in relation to accreditation of education supporting the AHRG Pathway?
3.15. Please provide any other feedback you have on the procedures for accreditation that are being developed.
REFERENCES


Universities Australia (UA) and Professions Australia (PA) 2016, Joint statement of principles for professional accreditation, viewed 8 January 2018, https://www.universitiesaustralia.edu.au/uni-participation-quality/Quality/Principles-for-Professional-Accreditation#.Wl1wbyWaUk
## DRAFT RESOURCE 1: COMPETENCY FRAMEWORK

1. An Allied Health Rural Generalist upholds professional and ethical standards in the rural and remote setting.

<table>
<thead>
<tr>
<th>Enabling competencies</th>
<th>Performance criteria After completing Level 1 education and training, an AHRG:</th>
<th>Performance criteria After completing Level 2 education and training, an AHRG:</th>
<th>Education Framework reference point</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1. Practises professionally and ethically</td>
<td>• Applies professional and ethical standards in responding to ethical challenges common in rural and remote settings</td>
<td>• Promotes adherence to professional and ethical standards in responding to ethical challenges common in rural and remote settings through the design or revision of processes</td>
<td>• Domain 2. Core unit 5. Ethical practice</td>
</tr>
</tbody>
</table>
| 1.2. Promotes cultural competence | • Collaborates with the community, senior staff and cultural experts to develop a comprehensive picture of cultural needs for the local community  
• Communicates effectively in a culturally safe manner  
• Proposes changes to own and team practice to enhance cultural appropriateness and outcomes for the local community | • Incorporates cultural competence principles into local service planning  
• Identifies and utilises resources to support culturally appropriate and safe service delivery for the local community  
• Actions changes to enhance cultural appropriateness and outcomes for the local community | • Domain 2. Core unit 3. Cultural competence |
| 1.3. Promotes evidence-based professional practice | • Sources and incorporates evidence into practice | • Leads the incorporation of evidence in the design, implementation and evaluation of services in rural and remote settings | • Domain 1. Core unit 2. Evidence-based decision making |
2. An Allied Health Rural Generalist collaborates to plan and develop rural health service delivery models, strategies and policies to better meet the needs of the community.

<table>
<thead>
<tr>
<th>Enabling competencies</th>
<th>Performance criteria</th>
<th>Performance criteria</th>
<th>Education Framework primary reference point</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1. Engages with the community</td>
<td>• Recommends appropriate and relevant community engagement mechanisms in rural and remote settings</td>
<td>• Initiates and leads effective community engagement activities in relation to local service</td>
<td>• Domain 2. Core unit 4. Community engagement</td>
</tr>
<tr>
<td></td>
<td>• Participates in community engagement activities in rural and remote settings</td>
<td>• Uses findings from community engagement activities to define community needs or contribute to broader community needs analysis</td>
<td></td>
</tr>
<tr>
<td>2.2. Analyses available information</td>
<td>• Interprets community demographic and health information in relation to the local service</td>
<td>• Leads analysis of community profile and service evaluation information</td>
<td>• Domain 1. Core unit 3. Service development and planning</td>
</tr>
<tr>
<td></td>
<td>• Integrates knowledge of service evaluation results into service planning and development</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Integrates knowledge of health prevention/promotion programs into service planning and development</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX 1

An accreditation system for rural generalist education and training for the allied health professions

| 2.3. Establishes partnerships within and outside the health sector | • Recognises implications of health system structure, funding and organisation on local service delivery  
• Recognises the influence of intersectoral relationships on the delivery of healthcare in rural and remote communities  
• Consolidates, applies and extends entry level knowledge, skills and abilities to collaborate in practice | • Promotes awareness of rural generalist service delivery models, strategies and policies  
• Collaborates with those in the broader health system and intersectorally to plan and develop service delivery models relevant to local service need | • Domain 2. Core unit 1. Health care systems and rural service models  
• Domain 1, Core unit 2. Primary health care |
| --- | --- | --- | --- |
| 2.4. Compares and contrasts rural generalist service delivery models, strategies and policies to meet local need | • Identifies the main forms of rural generalist service delivery models, strategies and policies  
• Identifies strengths, challenges and requirements for successful implementation for the main forms of rural generalist service delivery models, strategies and policies  
• Participates in the scoping and development of a rural generalist service delivery model, strategy or policy for the local service | • Identifies impacts and opportunities of rural generalist service delivery models, strategies and policies for local services  
• Proposes recommendations for rural health service delivery models, strategies and policies | • Domain 2. Core unit 1. Health care systems and rural service models |
### APPENDIX 1
An accreditation system for rural generalist education and training for the allied health professions

#### 3. An Allied Health Rural Generalist implements rural health service delivery models, strategies and policies to better meet the needs of the community.

<table>
<thead>
<tr>
<th>Enabling competencies</th>
<th>Performance criteria</th>
<th>Performance criteria</th>
<th>Education Framework reference point</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>After completing Level 1 education and training, an AHRG:</td>
<td>After completing Level 2 education and training, an AHRG:</td>
<td></td>
</tr>
<tr>
<td>3.1. Implements rural generalist service delivery models safely, effectively and efficiently</td>
<td>• Participates in the implementation of a rural generalist service delivery model, strategy or policy for the local service</td>
<td>• Leads and manages the implementation of a rural generalist service delivery model, strategy or policy for the local service, with support of senior colleagues</td>
<td>• Domain 1. Core unit 1. Project management and leading change</td>
</tr>
<tr>
<td></td>
<td>For example:</td>
<td>For example:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Participates in the implementation, expansion or review of telehealth service delivery</td>
<td>• Leads (with support) the implementation, expansion or review of telehealth service delivery as part of the model of care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>And/or</td>
<td>And/or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Participates in the implementation, expansion or review of delegation to clinical support workers in accordance with delegation frameworks</td>
<td>• Leads (with support) the implementation, expansion or review of delegated practice as part of the model of care</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Domain 2. Optional unit 2. Delegation</td>
</tr>
<tr>
<td>And/or</td>
<td>And/or</td>
<td>And/or</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>• Participates in the implementation, expansion or review of skill sharing, including training, monitoring and governance processes</td>
<td>• Leads (with support) the implementation, expansion or review of a model of care that includes skill sharing</td>
<td>• Domain 2, Optional unit 3. Extended scope including skill sharing</td>
<td></td>
</tr>
<tr>
<td>And/or</td>
<td>And/or</td>
<td>• Domain 2, Optional unit 4. Partnerships and new services</td>
<td></td>
</tr>
<tr>
<td>• Participates in the development or review of partnerships with agencies in other sectors to bring ‘care closer to home’, including local service providers and rural-urban partnerships</td>
<td>• Leads (with support) the implementation, expansion or review of partnerships that deliver new or expanded services for local communities and bring ‘care closer to home’</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2. Implements primary health care initiatives in collaboration with partners</td>
<td>• Participates in the integration of the key principles and features of primary health care in local service delivery</td>
<td>• Domain 2, Core unit 2 Primary health care</td>
<td></td>
</tr>
<tr>
<td>3.3. Manages rural generalist service delivery models</td>
<td>• Participates in the management of finances and resources within the service</td>
<td>Performance may be extended beyond that achieved after completing Level 1 education and training such that the AHRG: • Undertakes (with support) the management of finances and resources within the service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Domain 1, Optional unit 1. Management skills</td>
<td></td>
</tr>
</tbody>
</table>
**APPENDIX 1**
An accreditation system for rural generalist education and training for the allied health professions

<table>
<thead>
<tr>
<th>3.4. Promotes education and supervision</th>
<th>• Participates in the education and formal clinical/professional supervision of students and staff</th>
<th>• Undertakes (with support) the education and formal clinical/professional supervision of students and staff</th>
<th>• Domain 1. Optional unit 2. Education and supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Participates in the management of people within the service to improve performance and drive change</td>
<td>• Undertakes (with support) the management of people within the service to improve performance and drive change</td>
<td>• Domain 1. Optional unit 1. Management skills</td>
<td>• Undertakes (with support) operational risk reporting, monitoring and management, presenting service management issues and proposed solutions to managers and executive</td>
</tr>
</tbody>
</table>
4. An Allied Health Rural Generalist evaluates services to improve quality and contribute to the evidence base for service provision in the rural and remote setting.

<table>
<thead>
<tr>
<th>Enabling competencies</th>
<th>Performance criteria</th>
<th>Performance criteria</th>
<th>Performance criteria</th>
<th>Education Framework reference point</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>After completing Level 1 education and training, an AHRG:</td>
<td>After completing Level 2 education and training, an AHRG:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1. Manages clinical risk</td>
<td>• Identifies and reports clinical risks, hazards and opportunities for improvement in the practice context</td>
<td>• Reviews clinical risks in the local service/team and develops recommendations to prevent or mitigate identified risk</td>
<td></td>
<td>● Domain 1. Core unit 4. Quality improvement and clinical risk management</td>
</tr>
<tr>
<td>4.2. Implements quality improvement initiatives</td>
<td>• Contributes to quality improvement initiatives within the team/service</td>
<td>• Leads quality improvement initiatives for the team/service</td>
<td></td>
<td>● Domain 1. Core unit 4. Quality improvement and clinical risk management</td>
</tr>
<tr>
<td>4.3. Engages in research</td>
<td>• Participates in research or knowledge translation activities associated with rural generalist service development or quality improvement, leading or managing (with support) specific components</td>
<td>Performance may be extended beyond that achieved after completing Level 1 education and training such that the AHRG: • Leads or manages (with support) research or knowledge translation activities associated with rural generalist service development or quality improvement</td>
<td></td>
<td>● Domain 1. Optional unit 3. Applied research in rural and remote contexts</td>
</tr>
</tbody>
</table>
5. An Allied Health Rural Generalist applies their professional knowledge and skills to provide services to better meet the needs of the community in rural and remote settings.

<table>
<thead>
<tr>
<th>Enabling competencies</th>
<th>Performance criteria</th>
<th>Performance criteria</th>
<th>Education Framework reference point</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1. Provides services to client groups across the lifespan and continuum of care,</td>
<td>- Consolidates, applies and extends entry level knowledge, skills and abilities in practice, including a specific focus on clinical presentations and conditions highly relevant to the local service setting</td>
<td>- In the provision of care, demonstrates clinical decision-making capability with a high level of independence in increasingly complex situations</td>
<td>- Domain 3. Core clinical practice (profession-specific)</td>
</tr>
<tr>
<td>with a large range of clinical conditions</td>
<td>- In the provision of care, plans and prepares, performs/delivers, monitors and evaluates, and modifies as necessary</td>
<td>- Assertively communicates advice and recommendations for patient care relevant to the scope of the profession and level of expertise</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Assertively communicates advice and recommendations for patient care relevant to the scope of the profession and level of expertise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2. Implements effective, high quality, evidence-based care relevant to own</td>
<td>- Applies and extends knowledge, skills and abilities in delivering clinical care using rural generalist service delivery strategies and inter-agency and professional networks</td>
<td>- Delivers clinical care using rural generalist service delivery strategies with a high level of proficiency</td>
<td>- Domain 3. Clinical focus areas (profession-specific)</td>
</tr>
<tr>
<td>profession using rural generalist service delivery strategies and networks</td>
<td></td>
<td>- Effectively collaborates with other services and agencies relevant to client care including establishing and maintaining networks</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 5.3. Extends scope of practice (complex practice) and/or dual qualification role*

- Is exposed to practice that extends scope of practice or provides a dual professional role in the team service model
- Implements extended scope (complex practice) and/or dual qualification role identified in the team service model with appropriate safety, evaluation, governance and reporting processes in place
- Demonstrates adherence to safety, evaluation, governance and reporting processes
- Domain 4. Extended scope (complex practice) and dual qualification

### 5.4. Implements skill sharing#

- Delivers extended scope (skill sharing) tasks identified in the team service model
- Demonstrates adherence to safety, evaluation, governance and reporting processes
- Delivers extended scope (skill sharing) tasks identified in the team service model
- Demonstrates adherence to safety, evaluation, governance and reporting processes
- Domain 4. Extended scope (skill sharing)

*Profession-specific clinical focus areas and extended scope and dual qualification tasks, beyond core clinical practice, as identified in the AHRG Education Framework, are listed in Table A1.1.

# Skill sharing task clusters can potentially be implemented by a range of professions. Those identified in the AHRG Education Framework are listed in Table A1.2. Refer to the AHRG Education Framework for details relating to tasks currently determined to be appropriate for skill sharing.
## Appendix 1

An accreditation system for rural generalist education and training for the allied health professions

### Table A1.1. Profession-specific clinical focus areas and extended scope and dual qualification tasks, beyond core clinical practice, as identified in the AHRG Education Framework

<table>
<thead>
<tr>
<th>Profession</th>
<th>Clinical focus areas (client group or category of clinical presentation) for each profession</th>
<th>Extended scope (complex practice) and dual qualification tasks for each profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition &amp; Dietetics</td>
<td>• Generalist dietetics practice&lt;br&gt;• Paediatrics&lt;br&gt;• Food service management&lt;br&gt;• Diabetes&lt;br&gt;• Prevention &amp; self-management</td>
<td>• Comprehensive diabetes management including Credentialed Diabetes Educator (dual qualification) and advice on insulin dose&lt;br&gt;• Gastrostomy management</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>• Paediatrics&lt;br&gt;• Oedema &amp; lymphoedema&lt;br&gt;• Hand therapy&lt;br&gt;• Rehabilitation&lt;br&gt;• Home modification &amp; equipment prescription&lt;br&gt;• Prevention &amp; self-management</td>
<td>• n/a</td>
</tr>
<tr>
<td>Podiatry</td>
<td>• Foot morbidity in high risk groups&lt;br&gt;• Wound management&lt;br&gt;• Oedema management&lt;br&gt;• Musculoskeletal&lt;br&gt;• Prevention &amp; self-management</td>
<td>• Endorsement for scheduled medicines</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>• Quality use of medicines, including medication safety&lt;br&gt;• Distribution activities&lt;br&gt;• Specific practice areas (e.g. renal, oncology, palliative care)&lt;br&gt;• Prevention &amp; self-management</td>
<td>• n/a</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>• Musculoskeletal&lt;br&gt;• Paediatrics&lt;br&gt;• Continence &amp; women’s health&lt;br&gt;• Sub-acute/step-down rehabilitation&lt;br&gt;• Prevention &amp; self-management</td>
<td>• Primary contact – neuromusculoskeletal/orthopaedic (complex practice)</td>
</tr>
<tr>
<td>Radiography (medical imaging)</td>
<td>• Commenting&lt;br&gt;• Radiographic advice for remote area operators</td>
<td>• Sonography (dual qualification)</td>
</tr>
</tbody>
</table>
### APPENDIX 1

An accreditation system for rural generalist education and training for the allied health professions

<table>
<thead>
<tr>
<th>Speech pathology</th>
<th>Extended scope (skill sharing) tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Paediatric speech and language</td>
<td>Refer to the AHRG Education Framework for details relating to tasks currently determined to be appropriate for skill sharing.</td>
</tr>
<tr>
<td>• Paediatric feeding</td>
<td></td>
</tr>
<tr>
<td>• Adult rehabilitation</td>
<td></td>
</tr>
<tr>
<td>• Adult neurology</td>
<td></td>
</tr>
<tr>
<td>• Adult dysphagia</td>
<td></td>
</tr>
<tr>
<td>• Aboriginal and Torres Strait Islander</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ear health</td>
</tr>
<tr>
<td></td>
<td>• Prevention &amp; self-management</td>
</tr>
<tr>
<td></td>
<td>• n/a</td>
</tr>
</tbody>
</table>

### Table A1.2. Skill sharing task clusters that can potentially be implemented by a range of professions, as identified in the AHRG Education Framework. Refer to the AHRG Education Framework for details relating to tasks currently determined to be appropriate for skill sharing.

<table>
<thead>
<tr>
<th>For all professions</th>
<th>Core skill shared tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• High risk foot screen</td>
</tr>
<tr>
<td></td>
<td>• Falls risk screen</td>
</tr>
<tr>
<td></td>
<td>• Psychosocial screen</td>
</tr>
<tr>
<td></td>
<td>• Carer strain index</td>
</tr>
<tr>
<td></td>
<td>• Mental health first aid</td>
</tr>
<tr>
<td></td>
<td>• Subjective screening assessment of pressure area risk including Waterlow (pressure risk screen)</td>
</tr>
<tr>
<td></td>
<td>• Malnutrition risk screen (using MST)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skill share options</th>
<th>Assessment and intervention for defined tasks relating to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Activities of daily living and function</td>
</tr>
<tr>
<td></td>
<td>• Mobility and transfers</td>
</tr>
<tr>
<td></td>
<td>• Cognition, perception and memory</td>
</tr>
<tr>
<td></td>
<td>• Developmental and child health</td>
</tr>
<tr>
<td></td>
<td>• Diet and nutrition</td>
</tr>
<tr>
<td></td>
<td>• Musculoskeletal</td>
</tr>
<tr>
<td></td>
<td>• Foot care (high risk groups)</td>
</tr>
<tr>
<td></td>
<td>• Pressure care, scars and wounds</td>
</tr>
<tr>
<td></td>
<td>• Social and psycho-social</td>
</tr>
<tr>
<td></td>
<td>• Swallowing</td>
</tr>
<tr>
<td></td>
<td>• Communication</td>
</tr>
</tbody>
</table>

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DRAFT RESOURCE 2: ACCREDITATION STANDARDS

These Accreditation Standards have been adapted, with permission, from the Australian Dental Council Accreditation Standards for Dental Practitioner Programs. They include five Domains, with a descriptive Standard Statement. Each Standard Statement is supported by a set of Criteria. The Criteria are indicators that set out what is expected of an accredited program to meet each Standard Statement (they are not sub-standards) (ADC 2014b).

<table>
<thead>
<tr>
<th>Domain and Standard Statement</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Public Safety.</strong> Public safety is assured.</td>
<td>1.1 Protection of the public and the care of patients are prominent amongst the guiding principles of the educational program, work-integrated learning and student learning outcomes.</td>
</tr>
<tr>
<td></td>
<td>1.2 Students meet the requirements to practice independently in their profession in Australia.</td>
</tr>
<tr>
<td></td>
<td>1.3 Students meet all requirements for practice in the location and organisational context in which work-integrated learning will be undertaken.</td>
</tr>
<tr>
<td></td>
<td>1.4 Students are supervised by suitably qualified health practitioners, who meet the requirements to practice independently in their profession in Australia, during work-integrated learning.</td>
</tr>
<tr>
<td></td>
<td>1.5 Health services providing work-integrated learning have robust quality and safety policies and processes and meet all relevant regulations and standards.</td>
</tr>
<tr>
<td></td>
<td>1.6 The provider holds students and staff to high levels of ethical and professional conduct.</td>
</tr>
<tr>
<td><strong>2. Academic Governance and Quality.</strong> Academic governance and quality assurance processes are effective.</td>
<td>2.1 The provider has robust academic governance arrangements in place for the program of study that includes systematic monitoring, review and improvement.</td>
</tr>
<tr>
<td></td>
<td>2.2 Quality improvement processes use student and other evaluations, internal and external academic and professional peer review to improve the program.</td>
</tr>
<tr>
<td></td>
<td>2.3 There is relevant external input to the design and management of the program, including from representatives of rural and remote health services.</td>
</tr>
<tr>
<td></td>
<td>2.4 Mechanisms exist for responding within the curriculum to contemporary developments in health professional education and practice.</td>
</tr>
</tbody>
</table>
### APPENDIX 2

An accreditation system for rural generalist education and training for the allied health professions

#### 3. Program of Study.

Program design, delivery and resourcing enable students to achieve the required professional attributes and competencies.

<table>
<thead>
<tr>
<th>3.1 A coherent educational philosophy informs the program of study design and delivery.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2 Program learning outcomes address all the relevant competencies.</td>
</tr>
<tr>
<td>3.3 The quality and quantity of work-integrated learning is sufficient to produce a graduate competent to practice with a rural generalist scope.</td>
</tr>
<tr>
<td>3.4 Learning and teaching methods are intentionally designed and used to enable students to achieve the required learning outcomes.</td>
</tr>
<tr>
<td>3.5 Graduates are competent in research literacy for the level and type of the program.</td>
</tr>
<tr>
<td>3.6 Principles of inter-professional learning and practice are embedded in the curriculum.</td>
</tr>
<tr>
<td>3.7 Teaching staff are suitably qualified and experienced to deliver the units that they teach.</td>
</tr>
<tr>
<td>3.8 Learning environments support the achievement of the required learning outcomes.</td>
</tr>
<tr>
<td>3.9 Facilities and equipment are accessible, well-maintained, fit for purpose and support the achievement of learning outcomes.</td>
</tr>
<tr>
<td>3.10 Cultural competence is integrated within the program and clearly articulated as required learning outcomes: this includes Aboriginal and Torres Strait Islander cultures.</td>
</tr>
<tr>
<td>3.11 The program has the resources to sustain the quality of education that is required to facilitate the achievement of the necessary competencies.</td>
</tr>
</tbody>
</table>

#### 4. The Student Experience.

Students are provided with equitable and timely access to information and support.

<table>
<thead>
<tr>
<th>4.1 Course information is clear and accessible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2 Admission and progression requirements and processes are fair and transparent.</td>
</tr>
<tr>
<td>4.3 Students have access to effective grievance and appeals processes.</td>
</tr>
<tr>
<td>4.4 The provider identifies and provides support to meet the academic learning needs of students.</td>
</tr>
<tr>
<td>4.5 Students are informed of and have access to personal support services provided by qualified personnel.</td>
</tr>
<tr>
<td>4.6 Students are represented within the deliberative and decision making processes for the program.</td>
</tr>
<tr>
<td>4.7 Equity and diversity principles are observed and promoted in the student experience.</td>
</tr>
</tbody>
</table>
### 5. Assessment

Assessment is fair, valid and reliable.

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>5.1</td>
<td>There is a clear relationship between learning outcomes and assessment strategies.</td>
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<tr>
<td>5.2</td>
<td>Scope of assessment covers all learning outcomes relevant to the competencies.</td>
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<td>5.3</td>
<td>Multiple assessment tools, modes and sampling are used including direct observation in a clinical setting (including telehealth or simulated).</td>
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<td>5.4</td>
<td>Program management and co-ordination, including moderation procedures, ensure consistent and appropriate assessment and feedback to students.</td>
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<tr>
<td>5.5</td>
<td>Suitably qualified and experienced staff assess students</td>
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<tr>
<td>5.6</td>
<td>All learning outcomes are mapped to the required competencies, and assessed.</td>
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</tbody>
</table>