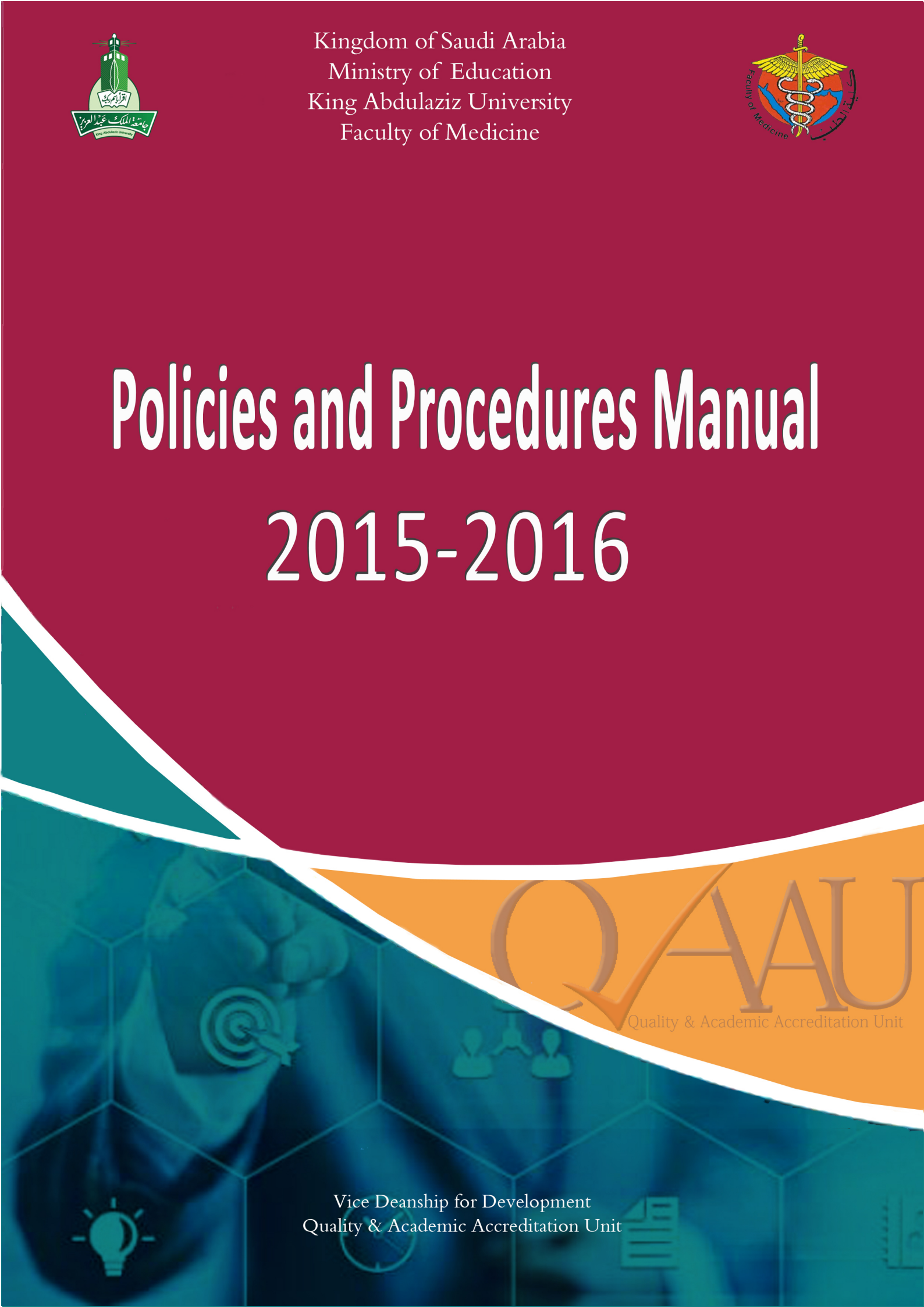
Kingdom of Saudi Arabia
Ministry of Education
King Abdulaziz University
Faculty of Medicine

Policies and Procedures Manual

2015-2016



Vice Deanship for Development
Quality & Academic Accreditation Unit

Policies and Procedures Manual

Table of Contents

Terms and Definitions

1. **Policies:** A policy is a statement stated to guide decision-making based on the framework of the institution's objectives, goals and management trends.

2. **Procedures:** A procedure is a "documented process": a series of prescribed steps which are followed in a specific regular order to secure adherence to the guidelines set in the policy the procedure adheres to. It describes the process: "who" does "what" and "when" "under what criteria" in a specific sequence.

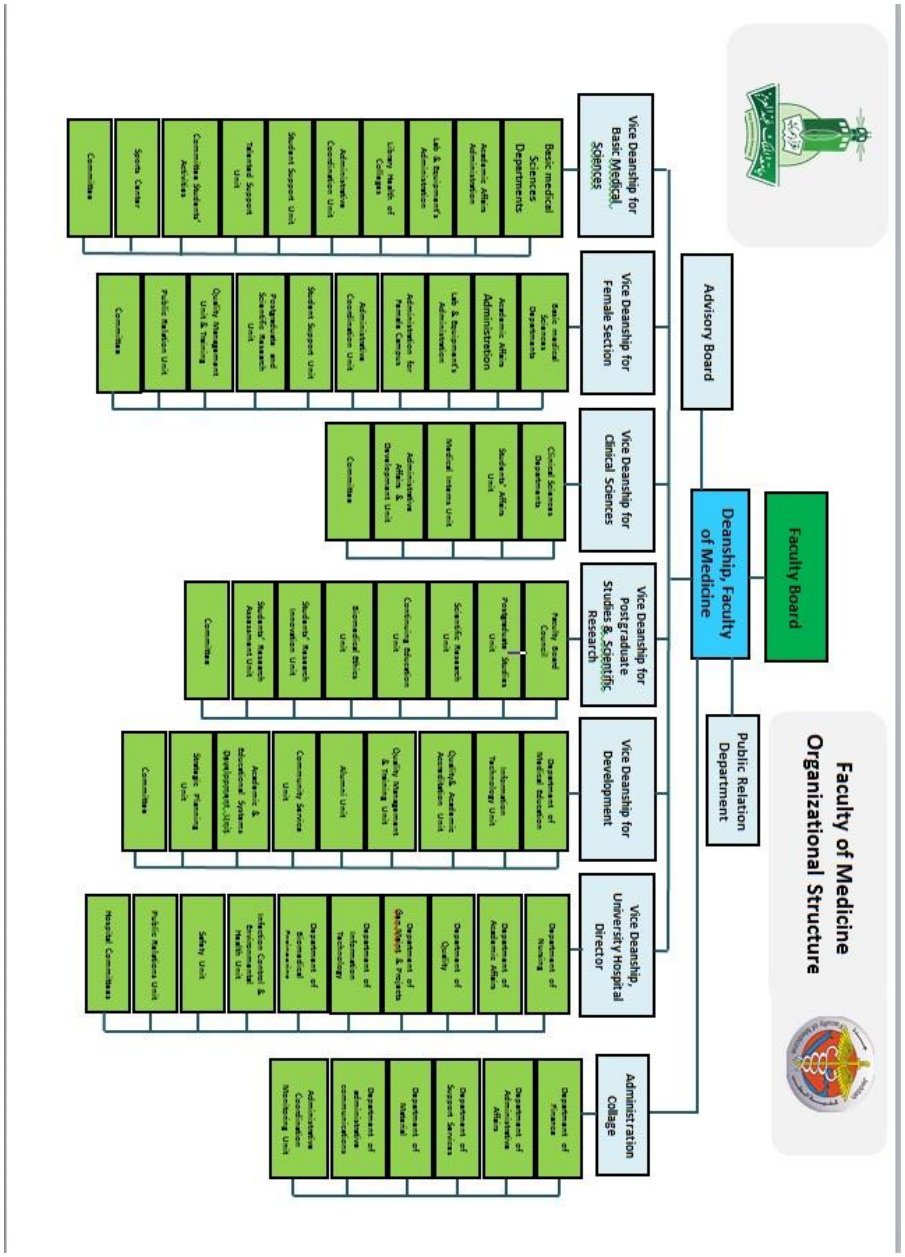
3. **Activity/ Task:** These are work instructions that describe how to accomplish the process. An activity is an action representing a step in the procedure. A task is a detailed description of an activity.

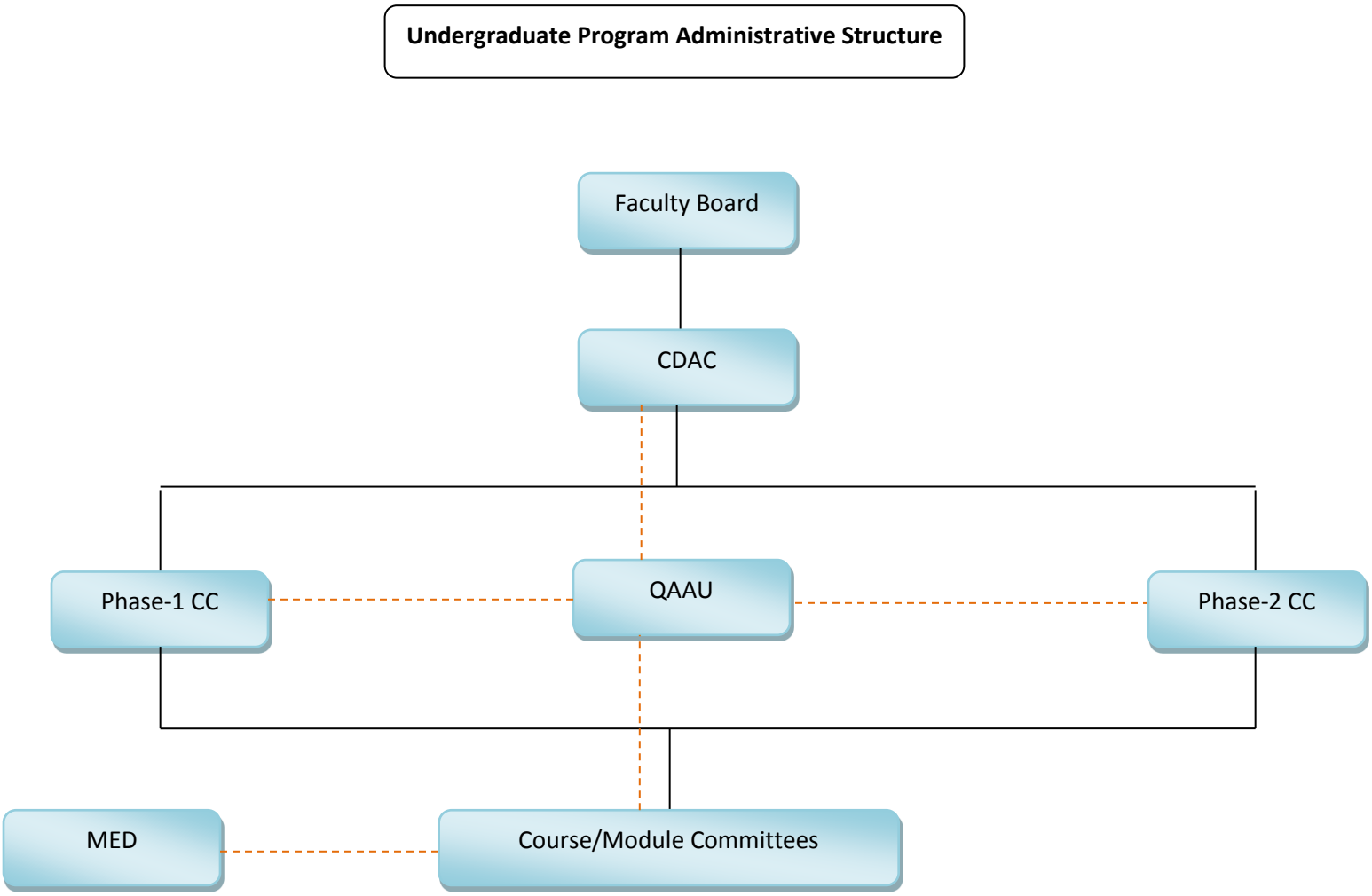
4. **Forms:** These are documentations used to create records, checklists, surveys; which constitute the basis of the process communications, audit materials, and process improvement initiatives. Records are a critical output of any procedure.

References:

http://store.bizmanualz

Faculty of Medicine Organizational Structure


Faculty of Medicine Organizational Structure
Advisory Board
Faculty Board
Deanship, Faculty of Medicine
Public Relation Department
Vice Deanship for Basic Medical Sciences
Basic medical Sciences Departments
Academic Affairs Administration
Lab & Equipment's Administration
Library, Health of Colleges
Administrative Coordination Unit
Student Support Unit
Talented Support Unit
Committee Students' Activities
Sports Center
Committee
Vice Deanship for Female Section
Academic Affairs Administration
Lab & Equipment's Administration
Administration for Female Campus
Administrative Coordination Unit
Student Support Unit
Postgraduate and Scientific Research Unit
Quality Management Unit & Training
Public Relation Unit
Committee
Vice Deanship for Clinical Sciences
Clinical Sciences Departments
Students' Affairs Unit
Medical Interns Unit
Administrative Affairs & Development Unit
Committee
Vice Deanship for Postgraduate Studies & Scientific Research
Faculty Board Council
Postgraduate Studies Unit
Scientific Research Unit
Continuing Education Unit
Biomedical Ethics Unit
Students' Research Innovation Unit
Students' Research Assessment Unit
Committee
Vice Deanship for Development
Department of Medical Education
Information Technology Unit
Quality& Academic Accreditation Unit
Quality Management & Training Unit
Alumni Unit
Community Service Unit
Academic & Educational Systems Development Unit
Strategic Planning Unit
Committee
Vice Deanship, University Hospital Director
Department of Nursing
Department of Academic Affairs
Department of Quality
Department of Medical & Projects
Department of Information Technology
Department of Biomedical Engineering
Infection Control & Environmental Health Unit
Safety Unit
Public Relations Unit
Hospital Committees
Administration College
Department of Finance
Department of Administrative Affairs
Department of Support Services
Department of Material
Department of administrative communications
Administrative Coordination Monitoring Unit


Undergraduate Program Administrative Structure
Faculty Board
CDAC
Phase-1 CC
QAAU
Phase-2 CC
MED
Course/Module Committees

Faculty of Medicine and Program Profile

The Faculty of Medicine (FOM) at King Abdulaziz University, Jeddah, Saudi Arabia was established in 1975. A traditional discipline-based curriculum was used to teach students. In the academic year 2006/2007, a new curriculum that is "Hybrid" curriculum was launched. It was approved by the Council of Higher Education in 2004/2005. The first program specifications document was approved by the Faculty Council in 5/4/1431H and by the University Council in 27/4/1431H.

Designing a curriculum for undergraduate medical students requires different specifications than any other ordinary discipline. It necessitates tailoring of the curriculum to produce a graduate who can solve routine and specific problems, a need which requires developing the higher cognitive and practical as well as the communication skills of the student. The curriculum is developed to respond to an ***educational need***, concerned with the thinking skills of the graduates in the clinical field; whereby graduates could not adequately apply the knowledge they acquired in real patient settings. That is why a modified curriculum is designed which is competency-based to meet the goal in graduating a physician who can deal with patients effectively and efficiently. The move is towards designing a curriculum to ensure the individuality of the discipline which mandates a specific approach in moulding the students' cognitive, motor, and attitude skills. In the Kingdom of Saudi Arabia, such need of that kind of curriculum originates from the scarcity of specialists and the increasing pace of development in the medical field; a problem which reflects its drawbacks on the national economy and community services.

Another determinant to which the curriculum should respond to is a ***social need***. Some cases passing by the primary health care units and general hospitals were never diagnosed and hence never treated due to the scarcity of Saudi consultants, specialists, and actually general practitioners; which necessitated the preparation of a greater cadre of five stars doctors having the attributes defined by the TUFH. Based on statistical results in the country, KSA needs 20 years in advance to fulfil the need to native physicians; in order to support the need for ***national policy*** development. This would be achieved starting with development of an undergraduate curriculum which equips its graduates with those attributes.

The new curriculum is also needed to avoid an ***economical need*** which results from cases who develop chronic degenerative changes in vital organs as the liver, kidneys, lungs and which result in organ failure which consumes the healthcare resources; and decreased productivity. Moreover, the Kingdom reflects

a special condition recognized in the continuous "Omrah" and "Hajj" seasons with millions of multinational incoming persons who might be carrying and manifesting with different infectious diseases in different disciplines. Hence, this necessitated the development of a curriculum which handles this diversity.

In addition, there is a serious inclination towards self-directed learning; consequently, the University encourages all Faculties to provide e- learning through educational programs; hence the Faculty of Medicine makes available an array of e- handouts and learning material through LMS as the blackboard, together with wide access to the internet in all buildings through a WiFi network.

Till 2008, there were no national accrediting agencies for medical schools; hence the FOM sought to adopt the accreditation standards of a renowned accrediting body that uses stringent standards to deliver high-quality medical education. The "Liaison Committee on Medical Education" of the USA and its Canadian partner "The Committee on Accreditation of Canadian Medical Schools (CACMS) were chosen for this purpose. The FOM initiated the process to meet the LCME standards in May 2008. Arrangement was made with three LCME surveyors. The FOM did indeed take good advantage of this self study process and the LCME standards to resolve any identified deficiencies and maintain the strengths. The report emphasized that the medical program in the FOM-KAU met the standards set for North American medical schools.

The second comprehensive evaluation of the program was conducted after completion of one complete cycle of the modified curriculum. It was conducted by the Quality and Academic Accreditation Unit through the Committee for Evaluation of Outcomes of Medical Curriculum (CEOMC) in the period 2012–2013. As a result, the final modifications were discussed and approved by the Main Curriculum Committee [currently called Committee for Development of Academic Curricula (CDAC)] in 28/ 2/ 1435, then by the Faculty Board in 14/1/1437, by Academic Accreditation Administration in 14/5/1437, by the University Curriculum Unit in 11/8/1437, and by the University Council in 22/8/1437. Modifications occurred at the meso- and micro-levels of the curriculum without making any major alterations in the program. The pre-clinical phase of the curriculum is composed of two years after the Preparatory Year (first year): the second year contain the Foundation course that prepares students to medical studies, core courses in basic medical sciences and early clinical exposure via the Basic Life Support course; the third year contains eight system-based modules and the Early Clinical Experience & Communication Skills course which is a bridging course to the clinical phase of the curriculum. The clinical phase of the curriculum is composed of three years which contain the four major clinical clerkships (Medicine, Surgery, Pediatrics and Obstetrics & Gynecology), Community & Family Medicine courses, Psychiatry & Behavioral Sciences, Professionalism, a combination of subspecialties and elective courses. Elective

courses in the 4th, 5th and internship years could be provided by colleges in KSA or abroad. For any elective, a formal letter is issued from the Electives Committee Coordinator, the Interns Office, and Vice Dean for Clinical Affairs displaying terms of reference including the general/ specific objectives of the elective course or the clinical rotation, the recommended methods for evaluating the students, and the names of supervisors/ coordinators from FOM-KAU. Electives are going to be revised to attract students to specialties in which there is shortage in the healthcare employability market. The program is completed by an internship year which is structured and evaluated.

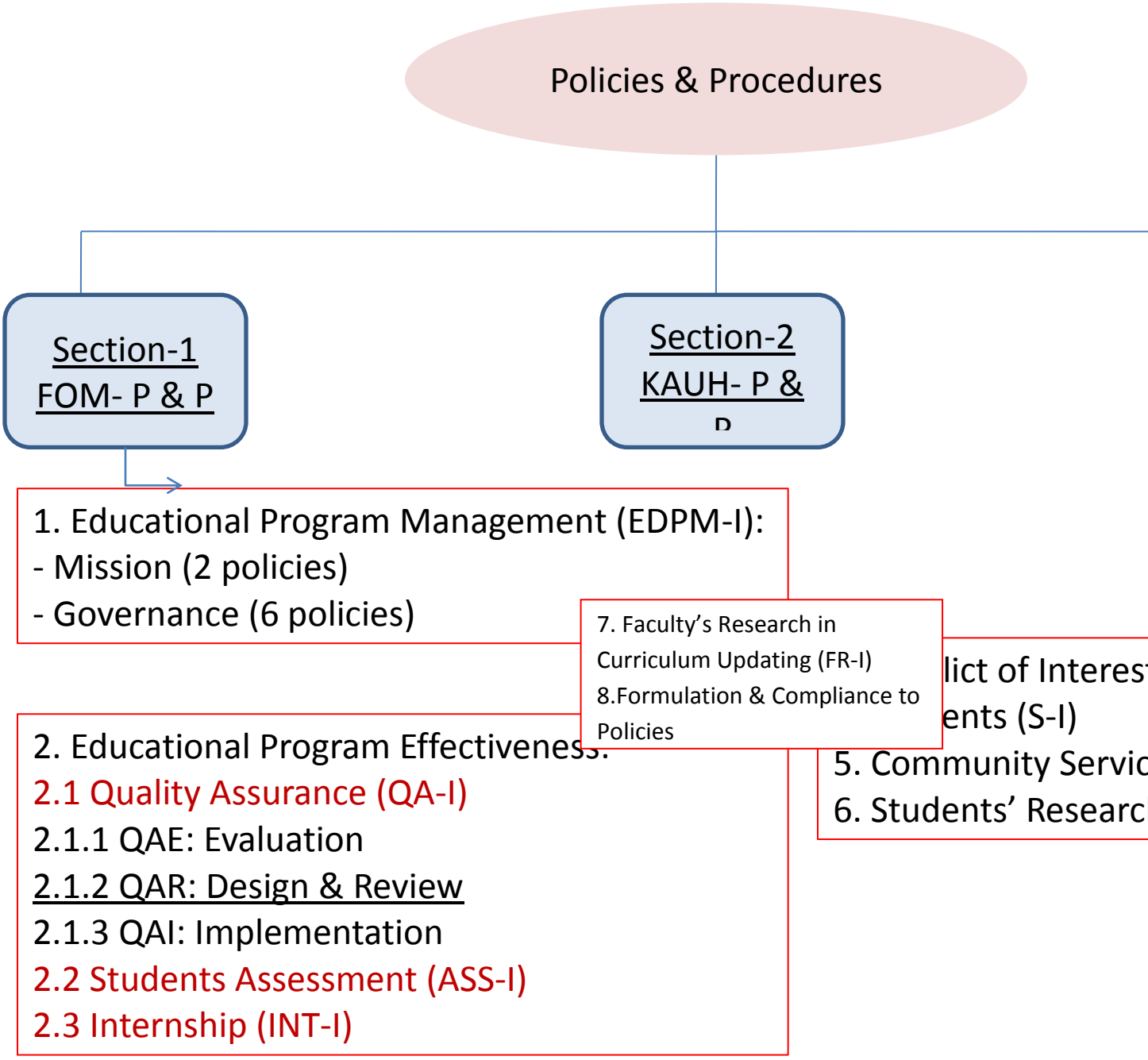
The modifications were informed by emphasizing that the educational program is mission-sensitive; its strategic goals and objectives align with those of the Faculty and the University. It equips undergraduate students with knowledge, skills and Islamic ethics, laws and attitudes; and enables them to make a valuable contribution to patients in primary and ambulatory healthcare settings; as well as, reinforces them to take the best advantage in the labour market. The program learning outcomes conform to the National Qualifications Framework (NQFW), national and international program standards and reflect international benchmarks of medicine adopted as the academic reference standards for the provision. The program also prepares graduates to lead a life-long learning attitude and to conduct research and scholarly activities through adopting the strategy of self-directed learning all through the curriculum and by providing the basics of research methodology incorporated in some obligatory courses as well as being provided as an elective course. Students are also encouraged to use the competencies they gained from the program to engage in community services either as part of an obligatory course or as a volunteer (extracurricular activities). The required knowledge, skills and attitudes were provided by a diversity of highly-qualified faculty members to enable graduates acquire the intended competencies and become capable physicians who meet the standards and employability needs.

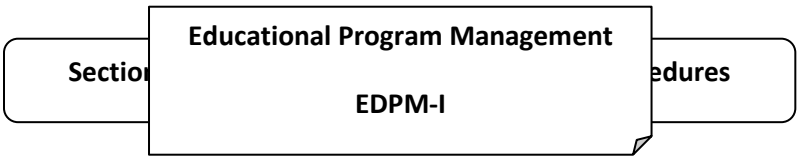
Courses delivered in the undergraduate program prepare graduates to attach to postgraduate programs in all specialties. They equip graduates with the basic knowledge, skills and attitudes which enable them to elaborate on them and expand their knowledge base, develop their skills competencies and apply a professional attitude during practice, within the medico-legal frame adopted by the institution. Consequently, the program is periodically monitored by the Quality & Academic Accreditation Unit to cope with any additional competencies required of the medical graduate. It is also reviewed by three curriculum committees informed by the qualifications framework set by the Saudi Council for Qualifications of Health Professions (NQFW); as well as national and international program standards (NCAAA and LCME); and national and international academic reference standards (SaudiMeds, CanMeds, ACGME).

The new modification to the curriculum considered the Canadian and American in addition to the national competencies during re-designing the courses to form a continuum between the undergraduate and the graduate programs to which KAU graduates apply after graduation. Such competencies were matched to each other and were found to be congruent.

To deliver this program and achieve the learning outcomes, the FOM recruits the highly qualified faculty and teaching staff. In 2014-2015, they total 817; out of the 379 faculty, 97% carry a doctoral degree and 3% a master degree. The total number of students in the FOM was 1848, thus constituting a student/staff ratio of 5: 1. King Abdulaziz University Hospital (KAUH) is the teaching hospital. It contains (760) with a capacity of 2-3 beds per student per day for any of the major clinical rotations. The required infrastructure is available and accessible in the institutional setting and is sufficient to enable faculty and teaching staff to conduct the curriculum and the students to achieve the learning outcomes. Besides the curricular activities, students are provided the opportunity to a broad spectrum of extra-curricular activities. Many units are established to provide, support, counseling and mentoring to students.

For the sustainability of the quality of the educational process, the FOM and the program have a rational, transactional and transformational, open-door leadership. Governance is established through: 1. University Bylaws which follow the bylaws of the Ministry of Education; 2. FOM Policies & Procedures; and 3. KAUH Policies & Procedures; in addition to an array of codes of practice.


Policies & Procedures
Section-1
FOM- P & P
Section-2
KAUH- P &
P
1. Educational Program Management (EDPM-I):
- Mission (2 policies)
- Governance (6 policies)
7. Faculty's Research in Curriculum Updating (FR-I)
8.Formulation & Compliance to Policies
lict of Interes
ents (S-I)
5. Community Servic
6. Students' Researc
2. Educational Program Effectiveness:
2.1 Quality Assurance (QA-I)
2.1.1 QAE: Evaluation
2.1.2 QAR: Design & Review
2.1.3 QAI: Implementation
2.2 Students Assessment (ASS-I)
2.3 Internship (INT-I)


Educational Program Management
EDPM-I

Document ID: EDPM-I.1	Title: Program Mission & Objectives		
Prepared By: QAAU	Date Prepared: 1/1/2015		
Approved By: Faculty Board	Date Approved: 27/10/2015		
Effective Date:			
Revision No.: --------	Reviewed By: --------	Date Reviewed: --------	Date Next Revision: --------

Policy (EDPM-I.1):

The educational program must have a written, ratified & publicized mission, which could be achieved on the long term; and objectives which are specific, feasible and ratified, that help in accomplishing the program mission.

Purpose:

1.1 The program mission & objectives must be well formulated to ensure its understanding on implementation.
The program mission & objectives must be ratified by the Faculty Council & approved by the Committee for Development of Academic Curricula (CDAC) to reinforce its implementation.

1.2 The program mission & objectives must be publicized through various methods to justify accountability.

Scope:

- Vice Deanship of Quality & Development
- Quality & Academic Accreditation Unit (QAAU)
- Students' Affairs Administration Office

Responsibilities:

- Vice Deanship of Quality & Development & (QAAU) reviews compliance and adherence to the policy

Procedure:

1. QAAU using a checklist ensures:
- the presence of a documented mission and objectives
- the alignment of the program mission with the Faculty and University missions
- that the mission and objectives are approved by the Committee for Development of Academic Curricula (CDAC)
- that the mission and objectives are ratified by the Faculty Council
- that the mission and objectives are publicized through various routes
2. QAAU reports compliance to the Vice Deanship of Quality & Development

Activities:

1. The Faculty Council Secretary sends to the Vice Dean for Quality & Development:
   - A copy of the approval of the ratified mission and objectives to the QAAU for documentation.
   - A copy of the approval of the stakeholders that are sent to the dean.
2. The Vice Dean for Quality & Development sends the above documents to the QAAU.
3. The QAAU ensures publicization of the approved educational program mission and objectives by the Students' Affairs Administration Office through checking the:
   - Faculty website
   - Students guide
   - Faculty Guide
   - Program Catalogue
4. The QAAU reports compliance status to the Vice Dean for Quality & Development.

Records:

1. The written feedback of stakeholders to the dean
2. A copy of the ratified mission and objectives with the Faculty Council meeting minutes
3. Observation checklists of publicization of the mission and objectives
4. Compliance report

Document ID: EDPM-I.2	Title: Review of Program Mission & Objectives		
Prepared By: QAAU	Date Prepared: 1/1/2015		
Approved By: Faculty Board	Date Approved: 27/10/2015		
Effective Date:			
Revision No.: --------	Reviewed By: --------	Date Reviewed: --------	Date Next Revision: --------

Policy (EDPM-I.2):

The Faculty/ program mission & objectives must be regularly reviewed every five years & updated via specified formal procedures in response to alterations in the external & internal environment.

Purpose:

2.1 The Faculty/ program mission & objectives must be reviewed and updated to meet alterations of the internal academic environment.
2.2 Review and updating are essential for meeting the vibrant innovative healthcare market needs.
2.3 Systematic annual review process enables the academic management leadership to undergo minor changes in the implementation process of the objectives
2.4 Long term review process enables the academic leadership to undergo major changes in the Faculty & program mission & objectives.

Scope:

- Academic Leaders
- Curriculum Committees (CCs): Phase-1 CC; Phase-2 CC; Committee for Development of Academic Curricula "CDAC"
- Faculty Administration Offices
- Vice Deanship of Quality & Development

- Quality & Academic Accreditation Unit (QAAU)
- Strategic Planning Unit (SPU)

Responsibilities:

- Academic Leaders & QAAU review the formulation of the mission and objectives.
- Dean ensures ratification of the updated mission & objectives in the (CCs) and Faculty Council
- Students' Affairs Administration Office ensures publicization of updated mission & objectives via various routes
- QAAU ensures alignment of the program mission with the Faculty mission that is also reviewed coincidently at the time of formulation of the strategic plan
- Vice Deanship of Quality & Development & (QAAU) reviews compliance and adherence to the policy

Procedure:

1. Academic Leaders (Dean; Vice Deans); Members of CCs; and QAAU review the educational program mission and objectives in relation to those of the Faculty.
2. Academic Leaders (Dean; Vice Deans); Members of CCs; and QAAU formulate and write the updated educational program mission and objectives.
3. The Dean distributes the proposed updated mission and objectives to all stakeholders (students, staff members, assisting staff members, administrators of the program and members of the Permanent Program Consultancy Committee)
4. Stakeholders discuss the updated mission and objectives each in the corresponding setting (Students' meetings; departmental meetings; curriculum committees; administrative committees and Permanent Program Consultancy Committee).
5. Stakeholders send their feedback to the Dean.
6. Dean enrolls the updated mission and objectives in the Faculty Council for approval.
7. QAAU receives a documented ratified copy of the approved updated mission and objectives.
8. Students' Affairs Administration Office publicizes the updated educational program mission and objectives through various routes to the students.
9. Heads of departments publicizes the updated educational program mission and objectives through various routes to all staff members (junior & senior); and residents.
10. QAAU ensures adherence to the procedure.

Activities:

2.1 Presence of formal specific procedures for reviewing the mission & objectives:

2.1.1 A review committee formed of the Academic Leaders (Dean; Vice Deans); Members of CCs; QAAU and SPU review the educational program mission and objectives.

2.1.2 The mission & objectives of the program must be reviewed every complete cycle of the program, i.e. every graduation; which coincides with the formulation of the strategic plan of the university and hence of the FOM.

2.1.3 Systematic annual review process is based on the results of retrospective evaluation of the program in the form of the graduate evaluation questionnaire, program report, scores of graduates in the licensing exam, results of surveys for evaluation of graduates by employers etc.

2.1.4 Longitudinal review process is based on the results of a more comprehensive self evaluation of the whole program and the institutional setting in which it is delivered; this would be every five years and done against predetermined standards & academic reference standards.

2.2 Presence of time table defining the dates of reviewing the program mission & objectives

2.2.1 Annual: 15th of September

2.2.2 Every 5 years: from the last self review; could be for re-accreditation.

2.3 The updating of program objectives must be consistent with the modifications done to the program mission.

2.3.1 The review committee ensures alignment of the objectives to the updated mission.

2.4 Causes of updating or maintaining mission & objectives should be justified by reports:

2.4.1 The QAAU issues an annual evaluation report of the educational program based on the results of retrospective evaluation of the program in the form of the courses evaluation questionnaires, graduate evaluation questionnaire, courses and program reports, scores of graduates in the licensing exam, results of surveys for evaluation of graduates by employers

2.4.2 The QAAU presents the report to the CDAC

2.4.3 The CDAC issues recommendations for the corresponding vice deanships based on the results of the report.

2.4.4 The QAAU issues a five-year evaluation report of the educational program based on the results of a SWOT analysis of the internal and external environments.

2.4.5 The report is discussed by the review committee and recommendations taken whether to update or maintain the mission and objectives decided.

2.5 In case of updating the mission & objectives:

2.5.1 The dean distributes the documented mission and objectives to students' leaders, head of departments and administrators of the program.

2.5.2 The students' leaders discuss the proposed mission and objectives with the students and raise their approval documented to the Dean.

2.5.3 The heads of departments discuss the mission and objectives in the departmental meetings and raise the approval documented to the Dean.

2.5.4 The administrative committees discuss the mission and objectives in their formal meetings and raise the approval documented to the Dean of.

2.5.5 The mission and objectives are approved in the Faculty Council.

2.5.6 The Faculty Council Secretary sends:

- A copy of the approval of the ratified mission and objectives to the QAAU for documentation.
- A copy of the approval of the stakeholders sent to the dean.

2.5.7 The Vice Dean for Quality & Development sends the approved mission and objectives to the Students' Affairs Administration Office.

2.5.8 The Students' Affairs Administration Office publicizes the approved educational program mission and objectives.

2.5.9 The Vice Dean for Quality & Development sends the approved mission and objectives to the Heads of Departments.

2.5.10 The Heads of Departments distribute the approved educational program mission and objectives to all junior and senior staff members, and residents.

2.5.11 The QAAU ensures adherence to the procedure through documentation, checklists, and observations.

Records:

1. Evaluation questionnaires reports (course questionnaires; graduate questionnaires)
2. Course reports and improvement action plans
3. Program report
4. QAAU annual evaluation report of the educational program
5. QAAU five-year report of the educational program
6. The review committee structure
7. The review committee meeting minutes
8. The Dean's formal letters to the stakeholders
9. The written feedback of stakeholders to the dean
10. Minutes of meetings of the stakeholders
11. A copy of the ratified mission and objectives with the Faculty Council meeting minutes

Document ID: EDPM-I.3	Title: Defining Educational Program Competences		
Prepared By: QAAU	Date Prepared: 01/1/2016		
Approved By: Faculty Board University Council	Date Approved: 07/ 11/ 2016 27/ 11/ 2017		
Effective Date:			
Revision No.: --------	Reviewed By: --------	Date Reviewed: --------	Date Next Revision: --------

12. Observation checklists of publicization of the mission and objectives

Policy (EDPM-I.3):

The mission and objectives impart distinguishing characteristics & attributes to the program. The program specifications must be based on the market employability skills & updated academic reference standards. The program must have a distinguished competitive stance at the regional and national level.

Purpose:

The program possesses characteristics & attributes in order to distinguish it from its counterparts & emphasize its competitive stance.

Scope:

- Academic Leaders
- Main Curriculum Committee (MCC)
- Vice Deanship of Quality & Development
- Quality & Academic Accreditation Unit (QAAU)

Responsibilities:

- The Vice Deanship of Quality & Development provides the QAAU with the latest market employability skills required by the National Qualifications Framework set by the Saudi Council for Health Specialties (SCHS).
- The QAAU evaluates the program against emerging qualifications and checks their feasibility within the available resources.
- The MCC (CDAC) reviews and/or approves the recommended modifications.
- Vice Deanship of Quality & Development & (QAAU) reviews compliance and adherence to the policy

- **Procedure:**

1. The Dean, and Vice Deans secure international, regional and national partnerships with other reputable universities.
2. The QAAU adopts the outlines of the latest competences in:
   - International Agencies taking into consideration the national culture and institutional capacity, ex. CanMeds and ACGME
   - National Competences, ex. SaudiMeds
   - Qualifications set in the National Qualifications Framework
3. The QAAU sets a comparison of the Faculty provision and the adopted outlines to ensure coverage of standards.
4. The QAAU plots a program matrix in case modifications are done.
5. The Vice Deanship of Quality & Development and MCC (CDAC) approve the adoption of the aforementioned qualifications and characteristics after securing the availability of the facilities and resources required for their accomplishment.

Records:

1. Latest National Qualifications Framework
2. Latest international academic reference standards (CanMeds; ACGME)
3. Latest SaudiMeds document
4. Program specifications
5. Program matrix
6. Table comparing the provision with the adopted competences

Document ID: EDPM-I.4	Title: Program Leadership and Organization		
Prepared By: QAAU	Date Prepared: 01/1/2016		
Approved By: Faculty Board University Council	Date Approved: 07/ 11/ 2016 27/ 11/ 2017		
Effective Date:			
Revision No.: --------	Reviewed By: --------	Date Reviewed: --------	Date Next Revision: --------

7. Copy of the documented approval of the MCC (CDAC) on the modifications

Policy (EDPM-I.4):

The academic leadership managing the program must be selected & evaluated according to objective transparent standards & criteria. The Faculty selects the program coordinator whether a vice dean, or academic coordinator based on documented publicized standards characterized by objectivity and transparency and accomplish availability of equal opportunities to each one. There must be an objective system for evaluating the academic leadership.

Performance Indicators:

1.2.1 Criteria which define selection of academic leaders of the program should include: scientific competency, specialized and qualified, have managerial & leadership skills, contributes in students' activities and support, contributes in aspects of quality & development, characterized by commitment and integrity, cooperative and have good respectable relations with colleagues and bosses.

1.2.2 Specify the sector in the Faculty which define those criteria

1.2.3 Those criteria should be ratified by the Faculty Council

1.2.4 Those criteria must be publicized to all stakeholders through various methods

1.2.5 Presence of a ratified system for evaluating academic leaders

1.2.6 To ensure triangulation of evidence concerning evaluation of leaders, the different sectors dealing with them should be involved in their evaluation and determining the evaluators' satisfaction index.

1.2.7 The evaluation system must be publicized to all

1.2.8 The evaluation system must depend on indicators of success of academic leadership in accomplishing the planned program mission and objectives

Purpose:

A smart qualified academic leadership secures proper implementation of the educational program and hence guarantees anticipated outcomes.

Scope:

- Academic Leaders
- Vice Deanship of Quality & Development
- Quality & Academic Accreditation Unit (QAAU)

Responsibilities:

1. The Vice Deanship of Quality & Development puts the criteria for selection and evaluation of academic leaders and staff members based on references to ensure validation.
2. The QAAU designs a portfolio guided by the criteria set by the higher administration which enables selection and also evaluation of academic leaders and staff members by their employers.
3. The Dean and Vice deans approve the portfolio
4. The Vice Deanship of Quality & Development ensures that it is implemented.

- **Procedure:**

1. The Vice Dean for Quality & Development proposes the criteria for selection & evaluation of academic leadership backed by references.
2. The QAAU designs a portfolio guided by the proposed criteria.
3. The Dean and Vice deans review the portfolio

4. The portfolio should be approved in the Faculty Council
5. The criteria for selection and evaluation is publicized to all stakeholders through the the Vice Deanship for Quality & Development.
6. The Vice Dean for Quality & Development distributes the portfolio to the:

- Vice deans to evaluate the dean
- Heads of departments to evaluate the vice deans and the dean.
- Staff members to evaluate heads of departments

7. Evaluation process occurs annually in the 1st of July of each academic year.
8. Filled portfolios are sent in a closed envelop from each party to the Vice Deanship for Quality & Development.
9. The Vice Deanship for Quality & Development and the QAAU analyze the results and issues a report that is to be sent to the dean.
10. In case there are unsatisfactory results concerning a specific person, the dean meets formally with the concerned person and discusses the reasons after which an objective judgment is executed.

Records:

1. Faculty Council approval of the selection/ evaluation portfolio
2. Filled portfolios
3. Report of dean and concerned person meeting in an incident (classified document)

Document ID: EDPM-I.5	Title: Program Management Bodies		
Prepared By: QAAU	Date Prepared: 01/1/2016		
Approved By: Faculty Board University Council	Date Approved: 07/ 11/ 2016 27/ 11/ 2017		
Effective Date:			
Revision No.: --------	Reviewed By: --------	Date Reviewed: --------	Date Next Revision: --------

Policy (EDPM-I.5):

The program must have formal control councils, units and committees that discuss, approve, monitor and evaluate its various activities and decisions.

Performance Indicators:

2.2.1 Presence of control councils for the program

2.2.2 Presence of consultancy committees which assist the control councils

2.2.3 Presence of a quality unit responsible for comprehensive evaluation of the program

2.2.4 Presence of specific formal rules for the constitution of those councils & committees.

2.2.5 Meticulous specification of the authorities & responsibilities of those councils, committees, and the quality unit.

2.2.6 The program councils and committees must meet regularly in the presence of a representative of the quality unit.

2.2.7 The contribution of those councils and committees in making decisions concerning management of the program is mandatory

2.2.8 Presence of a main curriculum committee

Purpose:

Presence of formal councils, committees, quality unit and MCC is essential to ensure continuous monitoring and evaluation of the program and hence continuous identification of issues which need improvement, thus avoiding undesired impact on the outcomes.

Scope:

- Dean
- Faculty Council members
- Coordinators of phases curriculum committees & MCC
- Staff members in those committees
- Vice Deanship of Quality & Development
- Quality & Academic Accreditation Unit (QAAU)

Responsibilities:

1. The dean issues information memos of the formation of curriculum committees and units
1. Each committee, or unit must have an annual action plan and meeting timetable approved by its council
2. A representative of the Quality Unit must attend curriculum committees meetings to be aware of any modifications and ensure compliance to the standards.
3. The Faculty Council takes decisions based on recommendations issued from the committees and quality unit.
4. The Vice Dean oversees the procedure.

- **Procedure:**

1. The dean issues information mandates of the formation of a:
- phase (I) and phase (II) curriculum committees
- MCC
- Vice Deans Consultancy Committee
- Students Affairs Consultancy Committee
- Quality & Academic Accreditation Unit
2. The mandates demonstrate:

- Structure of those committees and unit
- Tasks and terms of reference
- Lines of authority between committees, units, councils and the administration

3. Copy of the mandates is distributed to all stakeholders for publicization
4. Each committee or unit puts an annual action plan and meeting timetable approved by its council and sent to the Vice Deanship of Quality & Development.
5. The councils of committees and units must meet regularly and minutes documented and a copy sent to the Vice Deanship of Quality & Development and QAAU for documentation.
6. A representative of the Quality Unit must attend curriculum committees meetings to be aware of any modifications and ensure compliance to the standards.
7. Recommendations issued from the committees and quality unit must be discussed and taken into consideration on decision taking by the Faculty Council.

Records:

1. Information mandates for forming:

- MCC (CDAC)
- Phase (I) and (II) curriculum committees
- Quality & Academic Accreditation Unit
- Vice Deans Consultancy Committee
- Students' Affairs Consultancy Committee

2. Meeting minutes of the aforementioned committees and unit
3. Committees and unit action plans and meeting timetables

Document ID: EDPM-I.6	Title: Program Administrative Structure		
Prepared By: QAAU	Date Prepared: 01/1/2016		
Approved By: Faculty Board University Council	Date Approved: 07/ 11/ 2016 27/ 11/ 2017		
Effective Date:			
Revision No.: --------	Reviewed By: --------	Date Reviewed: --------	Date Next Revision: --------

Policy (EDPM-I.6):

The educational program must have a simple organizational structure that defines hierarchy, authority and responsibilities; and that clearly shows academic and administrative leadership of the program. The services administrations in the Faculty must effectively support the program.

Performance Indicators:

2.3.1 Presence of a simple organizational structure for the program

2.3.2 The structure must be ratified and publicized

2.3.3 The structure clearly demonstrates hierarchical relations between authorities

2.3.4 The structure clearly shows the support administrations for the program

2.3.5 Selection of the administrative sector members according to objective standards based primarily on competency and efficiency

2.3.6 Members of the administrative sector must be trained to develop and enhance their technical and behavioral skills and competencies

2.3.7 Critical specification of the jobs and empowerment of the supportive administrations for the program

2.3.8 Specification of the extent of effectiveness of contributions of the supportive administrations in providing academic and logistic support required for effective and efficient implementation of the program

Purpose:

The program organizational structure acts to effectively support the program academically and logistically and hence its proper implementation thus securing achievement of intended outcomes.

Scope:

- Dean
- Vice Dean for Quality & Development
- Faculty Council
- QAAU

Responsibilities:

1. The dean and Vice Dean for Quality & Development form the program organizational structure according to qualifications and efficiency; and define its responsibilities, authorization and relations.
2. The Faculty Council ratifies the structure.
3. The Vice Dean for Quality & Development distributes and publicizes the structure to all stakeholders and supportive administrations.
4. The Vice Dean for Quality & Development with the QAAU introduces training packages for members of the organizational structure to be able to perform their tasks effectively.

Procedure:

1. The dean issues information memos of the formation of the program organizational structure
2. The memos demonstrate:

- Structure of the organizational body

- Tasks and terms of reference
- Lines of authority between various stakeholders, committees, units, administrations and the structure

3. Copy of the memos is distributed to all stakeholders for publicization
4. Organizational structure meets regularly according to a predetermined schedule and recommendations issued from different sectors must be discussed and taken into consideration on decision taking by the Faculty Council.
5. Structure is reviewed every two years and changes performed when necessary with justifications.

Records:

1. Program organizational structure chart
2. Approval of Faculty Council
3. Minutes of structure sectors' meetings

Document ID: EDPM-I.7	Title: Program Information System		
Prepared By: QAAU	Date Prepared: 01/1/2016		
Approved By: Faculty Board University Council	Date Approved: 07/ 11/ 2016 27/ 11/ 2017		
Effective Date:			
Revision No.: --------	Reviewed By: --------	Date Reviewed: --------	Date Next Revision: --------

Policy (EDPM-I.7):

Program management depends on recent updated information system for the purpose of retaining, documenting, retrieving and publicizing all information related to the program so that it is available to all stakeholders and beneficiaries.

Performance Indicators:

2.4.1 Construction of databases which include various activities of the program: the number and names of students; structure, content and course of the program; number and percentage of failing and successful students; number and percentage of graduates; in addition to number and names of staff members and their assistants etc.

2.4.2 Regular updating of databases

2.4.3 The program must have its own specific system for retaining, submitting and retrieving documents

Purpose:

Presence of a system for retaining, submitting and retrieving documents will ensure effective contribution in increasing the effectiveness of performance of the program.

Scope:

- Vice Dean for Quality & Development
- QAAU

Responsibilities:

1. The QAAU is responsible for constructing a database for all that concern the educational program: course specifications, course reports, evaluation questionnaires and reports, program report, Faculty annual report, policies and procedures..etc
2. The Vice Dean for Quality & Development is the only person legible to allow any copy of the documents in the QAAU to be issued to any sector in the Faculty.

Procedure:

1. The Vice Dean for Quality & Development puts the flow chart of documents that concern the educational program.
2. The Vice Dean for Quality & Development classifies documents according to their degree of confidentiality.
3. The QAAU distributes the Course Cycle required documents to all course coordinators at the beginning of the academic year.
4. The documents are uploaded on the QAAU website at specific time scheduled for each course on the website.
5. The QAAU reviews the quality of the uploaded documents and send a report with recommendations to the course coordinators for any modifications according to the standards.
6. Hard copies after modifications are signed by the course coordinators and sent formally to the QAAU.
7. Retrieval of any document is only allowed after formal written permission from the Vice Dean for Quality & Development.
8. Documents that are required by accreditation reviewers and are classified confidential could be reviewed by surveyors in the QAAU.

Records:

1. Program File
2. Course specifications
3. Course reports
4. Evaluation reports: students', faculty's, graduates', and interns' questionnaires
5. Program report

6. Students' scores

Document ID: EDPM-I.8	Title: Financial and physical supportive resources		
Prepared By: QAAU	Date Prepared: 01/1/2016		
Approved By: Faculty Board University Council	Date Approved: 07/ 11/ 2016 27/ 11/ 2017		
Effective Date:			
Revision No.: --------	Reviewed By: --------	Date Reviewed: --------	Date Next Revision: --------

7. Data collected for database in database forms

Policy (EDPM-I.8):

There must be available the financial resources and the supportive physical facilities that ensure accomplishment of the program mission and objectives.

Performance Indicators:

1.3.1 Availability of the suitable financial sources that is adequate for practicing educational effectiveness.

1.3.2 There must be clear procedures to specify the spending priorities from budget assigned to the program; and there must be quantitative and qualitative methods that are objective and transparent for evaluating spending outcomes.

1.3.3 Effective implementation of the program requires supportive physical facilities as lecture halls, labs, equipments, consumables, hospital and training settings.

1.3.4 Ensure the availability and utilization of information technology infrastructure to secure effectiveness of the program

Purpose:

Presence of adequate financial and physical resources secures effectiveness of the program.

Scope:

- Dean
- Faculty Administration Director
- Hospital Director
- IT director
- Library director
- CSC director

Responsibilities:

1. The director of the Faculty administration must issue data in the forms submitted by the QAAU concerning the physical resources essential for running the program.
2. The director of the Faculty administration must issue an annual report revealing congruency between items of the actual expenditure and what was allocated in the approved budget.
3. The director of the Faculty administration must issue an annual report revealing:

- adequacy of lecture halls and small group learning classes
- convenience of lecture halls with number of students
- adequacy of labs
- labs which are suitably equipped according to the nature of the program provision
- availability of essential safety measures (guiding marks, fire extinguishers etc)
- healthy environment in the academic buildings and labs (aeration, natural light, cleanliness etc)

4. The hospital director must issue an annual report showing adequacy of clinical training sites: hospital, affiliations with other hospitals and primary healthcare centers with clear documented terms of reference.

5. The IT director must issue an annual report ensuring:

- adequacy and availability of computers to the students
- convenient ratio between the number of computers available for teaching and learning and the students
- regular checking of this ratio and defining the causes of inadequacy and setting solutions for improving that service
- availability of communication and information technology methods for students (internet, virtual classes, e-learning material etc)
- accessibility of internet to all students

6. The Library director must issue data in the forms submitted by the QAAU concerning the educational resources in the library essential for running the program.

Procedure:

1. In the 1st of May of each academic year, the above administrators fill the QAAU formats with data demonstrating the physical and educational resources essential to run the program effectively.
2. Forms are sent to the QAAU for processing and conversion to KPIs on which proper decisions could be taken by policy makers.
3. The QAAU evaluates the adequacy of educational resources in accordance with the KPIs and adopted standards.
4. The QAAU issues a report to the Vice Deanship for Quality & Development for decision making with the higher administration.
5. An action plan is set by the Vice Deanship for Quality & Development based on decisions taken by policy makers.
6. The Vice Dean for Quality & Development sends the action plan to the QAAU for monitoring and evaluation for another cycle.

Records:

1. Filled database forms
2. Processed database
3. Improvement action plan

Conflict of Interest

CON-I

Document ID: CON-I.1	Title: Conflict of Interest: General		
Prepared By: QAAU	**Date Prepared:** 15/4/2016		
Approved By: Faculty Board University Council	**Date Approved:** 07/ 11/ 2016 27/ 11/ 2017		
Effective Date:			
Revision No.: --------	**Reviewed By:** --------	**Date Reviewed:** --------	**Date Next Revision:** --------

Policy (CON-I.1):

1. All members of the Faculty Board and decision-making committees must provide an annual updated written ratification of any financial or credit interests between any of them and any members in the institution from the first, second, third or fourth family relative degree.

2. Any member must provide an annual updated written ratification of any financial or credit interests between any of them and any members in the institution from the first, second, third or fourth family relative degree once they are employed in the Faculty of Medicine.

An updated ratification is declared on involvement in any research project or assessment practice.

3. In any situation where a potential conflict of interest may arise, the person involved must withdraw from processes and decisions.

4. The Faculty Board is the only delegated authority to ratify contracts between the Faculty of Medicine and other party in which a Faculty Board member has any direct or indirect interests.

5. In case there is a relationship of any kind between a faculty member and a student or another colleague, he/she must declare this in writing in the department council or Faculty Board.

Purpose:

1. Promote good governance and objectivity.

2. The public and funding agencies and organizations have a legitimate expectation that the University will both conduct and be seen to conduct its affairs (academic & research) with integrity and objectivity.

3. The Faculty of Medicine must protect the integrity of the academic process and provide an environment in which all may reach their full potential, and in which all University members may perform at the highest levels of competence, integrity, and security.

4. Staff members have the right to be involved with other institutions or run private business so long these do not constitute a conflict of interest with the institution.

5. Occupying a position by any member in the Faculty of Medicine is not restrained provided that that member declares in writing any issues or relationships that might constitute a conflict of interest. The faculty Board must examine any issue that might raise a conflict of interest with transparency, neutrality and objectivity considering the institution's benefit as a priority.

Scope:

- Faculty Board members
- All staff in Faculty of Medicine
- Academic Leaders
- Faculty Administration Office

Responsibilities:

1. All members of the Faculty Board and decision-making committees must provide an annual updated written ratification of any financial or credit interests between any of them and any members in the institution from the first, second, third or fourth family relative degree.

1.1. This applies to any member in a decision-making council or the Faculty Board.

1.2. Any member in the Faculty Board or decision-making committees must retreat from any meeting where he or she has a direct or indirect financial, personal or other interest in any matter to be discussed at a meeting.

1.3. Any member must declare in writing any relationships or interests that might constitute a conflict of interest to the Head of the Faculty Board or any decision-making committee if that relationship or interest relate to the agenda of a particular meeting. The Head must withdraw that member from the meeting in case a conflict of interest is suspected.

2. Any member must provide an annual updated written ratification of any financial or credit interests between any of them and any members in the institution from the first, second, third or fourth family relative degree once they are employed in the Faculty of Medicine.

An updated ratification is declared on involvement in any research project or assessment practice.

2.1. If there is any suspected conflict of interest, that member in the Faculty of Medicine must inform in writing the corresponding administration before being involved in buying any goods from any party within which the member has an interest.

2.2. Should a staff member fail to disclose a conflict of interest, any person may inform Council of a conflict of interest of which that person may be aware.

3. Researchers, especially Principal Investigators (PIs), have special obligations to make full declarations of interest.

3.1. Investigators must, unless they have already done this as staff, before commencing a research project, declare any business, commercial or financial activities undertaken for significant financial gain that may raise a conflict or a possible conflict of interest with sponsors or entities affected by the research. The research contract may require a new disclosure form and may also require disclosure by all study participants, whether these are staff or not. In such cases the onus is on the PI to ensure that these disclosures are made.

3.2. All financial disclosures must be updated at the start of a research project during the period of the award or research project, either on an annual basis or as new significant financial interests arise.

3.3. The Deanship for Scientific Research play a special role in monitoring and managing research-related conflicts of interest by keeping records and reporting to funders on steps taken to manage conflicts of interest.

3.4. When the University carries out sponsored research through sub-grantees, contractors, or collaborators, the Deanship for Scientific Research must take reasonable steps to ensure that investigators working for such entities comply with any applicable conflict of interest requirements,

either by requiring those investigators to comply with this policy or by requiring the entities to provide assurances that will enable the University to comply with this policy.

3.5. The Deanship for Scientific Research shall certify, when required by a sponsor, that there is a written and enforced administrative process to identify and manage, reduce or eliminate conflicting interests with respect to all research projects for which funding is sought from a sponsor.

3.6. Prior to expenditure of any funds awarded by a sponsor, the Deanship for Scientific Research will report to the sponsor the existence of a conflicting interest if there is one (but not the nature of the interest or other details) and assure the sponsor that the interest has been managed, reduced or eliminated in accordance with this policy to protect the research from bias. This will be done within sixty days of the conflict of interest being identified. Any conflict of interest that emerges subsequent to its initial report will be similarly managed and reported.

3.7. The Deanship for Scientific Research must report any identified conflicts of interest between a researcher and a research project/research funder, and the steps taken to manage the conflict, to the University Vice President.

4. In any situation where a potential conflict of interest may arise, the person involved must withdraw from processes and decisions.

4.1. Any member with a conflict of interest must immediately retreat from any meeting or discussion of any situation in which he/she has any suspected conflict of interest and is not allowed to vote.

4.2. Researchers are required to postpone further investigative work where a conflict of interest is identified.

4.3. Conflict of interest must be documented in the meeting minutes of the Faculty Board or decision-making committees in which topics that relate to the declared conflict of interest is discussed.

5. Every staff member must declare any special relationships with another staff member or a student that may have a bearing on his or her work.

5.1 A staff member who has or had a special relationship to, or with, a student with whom he or she has job-related interaction, shall disclose the relationship to the Head of Department. The HOD shall keep a confidential written record of this and report this to the Dean. A Head of Department who has a special relationship with a student shall disclose this to the Dean, who shall keep a confidential record of this.

5.2 The HOD and Dean shall take whatever steps are necessary to ensure that conflicts of interest that arise through special relationships are disclosed and that the academic process is not compromised, that fairness in access to resources, opportunities and/or services is not damaged, and that bias, or perceptions of bias are avoided.

5.3 No faculty member is allowed to supervise or evaluate any student's academic task with whom he/she has a first, second, third or fourth relationship.

5.4 A member of staff who has or had any special relationship to, or with, a member of staff or job applicant in the department or section of which he or she is a member shall disclose the relationship to the Head of Department or Dean. In the case of a Head of Department who has a special relationship with a member of staff or job applicant the relationship must be reported to the relevant Dean, Director, or Registrar.

5.5 Any member who is appointed in a decision-making committee or meeting that discusses a matter that concerns any party or entity or another person who have a mutual interest with him/her, must declare that relationship to the Head of the Committee. If the Head of the committee is that person with the conflict of interest, he/she must declare it to the next relevant senior member who takes place in heading the meeting.

Procedure:

1. Procedure for Faculty Board members and decision-making committees:

1.1 Any member must declare in writing any conflict of interest to the Head of the Board or committee once he/she is appointed to that Board or committee. This declaration must be annually updated at the beginning of each academic year. The declaration is kept in custody of the Board or committee registrar.

1.2 The registrar arranges for perusing these declarations , keeps them and provides them for reviewing.

1.3 The registrar must make sure in each meeting that the declarations of conflict of interest are presented.

2. Procedure for annual update of all declarations

2.1 Declarations of conflict of interest must be annually updated by the Human Resources Administration Office.

2.2 Any changes in the provided declarations must be submitted by the concerned member and a new declaration form compiled.

3. Access to conflict of interest declarations

Only authorized members of the HR department and Procurement can access these records.

Definitions:

Conflict of interest: A conflict between one's interests whether, financial, trustee or personal with any family relative of the first, second, third or fourth degree or between him/her and any person or partnership or corporation or business or other organization that might affect the interests of the institution in which he/she works in.

Fiduciary: Relating to or involving a confidence or trustee.

Recuse: Retreat from voting or judging in any case to avoid any conflict of interest.

Family and special relationships: Any family relative of first, second, third or fourth degree; current or past marital relationships, friendships, business relationships; partnerships; interpersonal conflicts.

Financial interest: anything in which there is monetary relationship: honorarium, fees, shares, partnership interests, copyrights, patents.

Document ID: **CON-I.2 = ASS-I.2**	**Title:** **Assessment: Conflict of Interest**		
Prepared By: VDD QAAU	**Date Prepared:** 10/4/2015		
Approved By: **CDAC** **Faculty Council** **University Board**	**Date Approved:** 3/11/2015 5/ 1/ 2016 18/ 1/ 2016		
Effective Date:			
Revision No.: --------	**Reviewed By:** --------	**Date Reviewed:** --------	**Date Next Revision:** 5 years after approval

Policy (CON-I.2):

1. All members of the Faculty Board and decision-making committees must provide an annual updated written ratification of any financial or entrusted interests between any of them and any members in the institution from the first, second, third or fourth family relative degree.

2. Any member must provide an annual updated written ratification of any financial or credit interests between any of them and any members in the institution from the first, second, third or fourth family relative degree once they are employed in the Faculty of Medicine.
An updated ratification is declared on involvement in any research project or assessment practice.

3. In any situation where a potential conflict of interest may arise, the person involved must withdraw from processes and decisions.

4. The Faculty Board is the only delegated authority to ratify contracts between the Faculty of Medicine and other party in which a Faculty Board member has any direct or indirect interests.

5. In case there is a relationship of any kind between a faculty member and a student, he/she must declare this in writing in the department council or Faculty Board.

Purpose:

1. Promote good governance and objectivity.

2. To secure the expectations of public and funding agencies and organizations from the University in conducting its affairs (academic & research) with integrity and objectivity.

3. The Faculty of Medicine must secure an academic environment that is characterized by integrity and unleashes the full potential of its members and students.

Scope:

- Faculty Council members and members of Assessment Committees;
- All staff of the Faculty and all joint staff
- Academic leaders
- Faculty Administration Office

Responsibilities:

1. Every member of Faculty Council and of Assessment Committees must make a full declaration, in writing, of his or her immediate family members as required by the Faculty's Policies. These disclosures must be updated annually.

1.1. This applies to all members of Faculty Board and of nay Department Assessment Committee, including persons assigned with disciplinary action or providing grades and promotion.

1.2. A Faculty Council or an Assessment Committee member must withdraw from any meeting in which the issue to be discussed has any direct or indirect financial or personal relation to that member.

1.3. A Faculty Council and Assessment Committee member must, in writing, inform the chairperson of a meeting discussing assessment matter, before the meeting, of a conflict or possible conflict of interest contained in the agenda for that meeting and if confirmed must and if confirmed must retreat from the meeting.

1.4 Any person who is aware of a possible conflict of interest must inform the Faculty Board on case a faculty member fails to declare a conflict of interest.

2. Every academic or joint staff member must make a written declaration of any relationship with a family member of the first, second, third or fourth degree; this declaration must be annually updated.

2.1. In the course of carrying out assessment duties for the Faculty, staff members must notify the Faculty of any conflict- or possible conflict of interest before the Faculty assigns any assessment tasks from the staff member.

2.2. Any person who is aware of a possible conflict of interest must inform the Employee Affairs on case a faculty member fails to declare a conflict of interest.

3. In any situation where a potential conflict of interest may arise, the person involved must withdraw from processes and decisions.

3.1. Any member in Faculty Board or Departmental Assessment Committee with a potential conflict of interest must immediately withdraw from any meeting(s) that is related to the conflict. That member must not be involved in the discussion or voting on the issue of concern.

3.2. Conflicts of interest situations reported to, taken into account or otherwise considered by Faculty Council or an Assessment Committee shall be recorded, with adequate particulars, in the minutes of Faculty Council or of the Assessment Committee concerned.

4. Every staff member must declare any special relationships with another staff member or a student that may have a bearing on his or her work and assessment.

4.1 A staff member who has or had a special relationship to, or with, a student with whom he or she has job-related interaction, shall disclose the relationship to the Head of Department. The HOD shall keep a confidential written record of this and report this to the Dean. A Head of Department who has a special relationship with a student shall disclose this to the Dean, who shall keep a confidential record of this.

4.2 The HOD and dean disclose any conflicts of interest to ensure a sound academic environment that secures fair assessment and prevents bias.

4.3 No faculty member is allowed to supervise or evaluate any student's academic task with whom he/she has a first, second, third or fourth relationship.

4.4 A member of staff who has or had any special relationship to, or with, a member of staff in the department of which he or she is a member shall disclose the relationship to the Head of Department or Dean. In the case of a Head of Department who has a special relationship with a member of staff the relationship must be reported to the relevant Dean.

4.5 Any member who is appointed in a decision-making committee or meeting that discusses a matter that concerns any party or entity or another person who have a mutual interest with him/her, must declare that relationship to the Head of the Committee. If the Head of the committee is that person with the conflict of interest, he/she must declare it to the next relevant senior member who takes place in heading the meeting.

Procedure:

1. Procedure for Faculty Council members and members of Assessment Committee

1.1 The Dean requires each Faculty Council member and each Assessment Committee member to make a full disclosure on appointment, and annually before the first faculty Council meeting of each year.

1.2 The Dean and the Chair of the Assessment Unit arrange for scans of these.

1.3 The Dean and the Chair of the Assessment Unit maintain the register of declared interests and has it available at all Faculty Council and Assessment Unit meetings.

2. Procedure for annual update of all declarations

2.1 Conflicts of Interest Disclosures will be updated annually as part of the Assessment Unit annual data verification exercise.

2.2 When there has been a change in information, staff must complete and submit a new Disclosure Form.

3. Access to conflict of interest declarations

Only authorized members of the Assessment Unit can access these records.

Definitions:

Conflict of interest: A conflict between one's interests whether, financial, trustee or personal with any family relative of the first, second, third or fourth degree or between him/her and any person or partnership or corporation or business or other organization that might affect the interests of the institution in which he/she works in.

Fiduciary: trustee

Recuse: Retreat from voting or judging in any case to avoid any conflict of interest.

Family and special relationships: Any family relative of first, second, third or fourth degree; current or past marital relationships, friendships, business relationships; partnerships; interpersonal conflicts.

Financial interest: means anything of monetary value, including but not limited to, salary or other payments for services.

Students Assessment

ASS-I

Document ID: ASS-I.1	Title: Assessment Management		
Prepared By: VDD QAAU	**Date Prepared:** 03/06/2015		
Approved By: **CDAC** **Faculty Council** **University Board**	**Date Approved:** **3/11/2015** **5/1/2016** **18/1/2016**		
Effective Date:			
Revision No.: --------	**Reviewed By:** --------	**Date Reviewed:** --------	**Date Next Revision:** 5 years after approval

Policy:

Medical school should have supervisory structures that involve individuals with an appropriate range of expertise and knowledge in assessment. Lines of authority and responsibility must be set out to allow medical schools to plan curricula and associated assessments, put them into practice and review them.

Purpose:

1.3 Ensure methods and processes are consistent with Faculty assessment policies and bylaws
1.4 Ensure that the assessment strategies used yield valid and reliable results, and that the methods used have an educational impact, acceptable and cost effective.
1.5 Secure a comprehensive integrated assessment plan throughout the curriculum to ensure achievement of its learning outcomes
1.6 Ensure quality assurance of the assessment process and outcomes

Scope:

- Committee for Development of Academic Curricula (CDAC)
- Faculty Council (FC)
- Phase 1 & 2 Curriculum Committees

- The Main Faculty Assessment Committee (FMAC)
- Quality & Academic Accreditation Unit
- Medical Education Department
- Assessment Unit
- Course/ module coordinators (male and female)

Responsibilities:

- **FMAC and Quality & Academic Accreditation Unit:**
  - Put assessment policies

- **Quality & Academic Accreditation Unit:**
  - Ensure compliance to policies
  - Secure quality assurance of assessment process and outcomes
  - Verification of process
  - Validation of outcomes
  - Documentation of evidence of ideal practice and compliance to standards and policies

- **Phase 1 & 2 Curriculum Committees:**
  - Discuss policies with module directors and heads of departments

- **Committee for Development of Academic Curricula:**
  - Approve policies

- **Faculty Council:**
  - Ratifies policies

- **Assessment Unit & Course/ module committees:**
  - Implement policies
  - Generate exams according to quality assurance criteria

- **Medical Education Department:**
  - Supervises implementation of Assessment Unit

Procedure:

No.	Responsible Person(s)	Procedure	Rationale
1	FMAC and Quality & Academic Accreditation Unit	Put assessment policies	To regulate assessment process
2	Phase 1 & 2 Curriculum Committees	Familiarize module directors and heads of departments with policies	To ensure participation of stakeholders
3	Committee for Development of Academic Curricula & Faculty Council	Ratify and approve policies	To validate use of policies and ensure commitment and accountability
4	Assessment Unit & Course/ module committees	- Implement policies - Generate exams according to quality assurance criteria	- To ensure valid reliable results - To meet assessment standards
5	Quality & Academic Accreditation Unit	- Ensure compliance to policies -Secure quality assurance of assessment process and outcomes - Verification of process - Validation of outcomes	To provide evidence of ideal practice and compliance to standards and policies

Document ID: **ASS-I.2 = CON-I.2**	**Title:** **Assessment: Conflict of Interest**		
Prepared By: VDD QAAU	**Date Prepared:** 10/4/2015		
Approved By: **CDAC** **Faculty Council** **University Board**	**Date Approved:** 3/11/2015 5/ 1/ 2016 18/ 1/ 2016		
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Policy (ASS-I.2):

1. All members of the Faculty Board and decision-making committees must provide an annual updated written ratification of any financial or entrusted interests between any of them and any members in the institution from the first, second, third or fourth family relative degree.

2. Any member must provide an annual updated written ratification of any financial or credit interests between any of them and any members in the institution from the first, second, third or fourth family relative degree once they are employed in the Faculty of Medicine.

An updated ratification is declared on involvement in any research project or assessment practice.

3. In any situation where a potential conflict of interest may arise, the person involved must withdraw from processes and decisions.

4. The Faculty Board is the only delegated authority to ratify contracts between the Faculty of Medicine and other party in which a Faculty Board member has any direct or indirect interests.

5. In case there is a relationship of any kind between a faculty member and a student, he/she must declare this in writing in the department council or Faculty Board.

Purpose:

1. Promote good governance and objectivity.

2. To secure the expectations of public and funding agencies and organizations from the University in conducting its affairs (academic & research) with integrity and objectivity.

3. The Faculty of Medicine must secure an academic environment that is characterized by integrity and unleashes the full potential of its members and students.

Scope:

- Faculty Board members and members of Departmental Assessment Committees (DAC);
- All staff of the Faculty and all joint staff
- Heads of Departments (HOD)
- Dean
- Chair of Faculty Main Assessment Committee (FMAC)
- Vice Dean for Teaching Hospital (VD-KAUH)
- Director of Faculty Affairs (DFA)
- Employee Affairs in Faculty of Medicine & Teaching Hospital (EA- FOM) & (EA-KAUH)

Responsibilities & Procedure:

1. Every member of Faculty Board and of Departmental Assessment Committees must make a full declaration, in writing, of his or her immediate family members as required by the Faculty's Policies. These disclosures must be updated annually.

1.1. This applies to all members of Faculty Board and of nay Department Assessment Committee, including persons assigned with disciplinary action or providing grades and promotion.

1.2. A Faculty Board or an Departmental Assessment Committee member must withdraw from any meeting in which the issue to be discussed has any direct or indirect financial or personal relation to that member.

1.3. A Faculty Board and Departmental Assessment Committee member must, in writing, inform the chairperson of a meeting discussing assessment matter, before the meeting, of a conflict or possible

conflict of interest contained in the agenda for that meeting and if confirmed must retreat from the meeting.

1.4. Any person who is aware of a possible conflict of interest must inform the Faculty Board on case a faculty member fails to declare a conflict of interest.

2. Every academic and joint staff member must make a full declaration of his or her immediate family members on appointment to the Faculty. These disclosures must be updated annually. This must be done in writing.

2.1. In the course of carrying out assessment duties for the Faculty, staff members must notify the Employee Affairs in the Faculty/Hospital of any conflict- or possible conflict of interest before the Faculty assigns any assessment tasks from the staff member.

2.2. Any person who is aware of a possible conflict of interest must inform the Employee Affairs on case a faculty member fails to declare a conflict of interest.

3. In any situation where a potential conflict of interest may arise, the person involved must withdraw from processes and decisions.

3.1. Any member in Faculty Board or Departmental Assessment Committee with a potential conflict of interest must immediately withdraw from any meeting(s) that is related to the conflict. That member must not be involved in the discussion or voting on the issue of concern.

3.2. Conflicts of interest situations reported to, taken into account or otherwise considered by Faculty Board or an Departmental Assessment Committee shall be recorded, with adequate particulars, in the minutes of Faculty Board or of the Departmental Assessment Committee concerned.

4. Every staff member must declare any special relationships with another staff member or a student that may have a bearing on his or her work and assessment.

4.1 A staff member who has or had a special relationship to, or with, a student with whom he or she has job-related interaction, shall disclose the relationship to the Head of Department. The HOD shall keep a confidential written record of this and report this to the EA-FOM. A Head of Department who has a special relationship with a student shall disclose this to the Dean, who shall keep a confidential record of this.

4.2 The HOD and dean disclose any conflicts of interest to ensure a sound academic environment that secures fair assessment and prevents bias.

4.3 No faculty member is allowed to supervise or evaluate any student's academic task with whom he/she has a first, second, third or fourth relationship.

4.4 A member of staff who has or had any special relationship to, or with, a member of staff in the department of which he or she is a member shall disclose the relationship to the Head of Department or Dean. In the case of a Head of Department who has a special relationship with a member of staff the relationship must be reported to the relevant Dean.

4.5 Any member who is appointed in a decision-making committee or meeting that discusses a matter that concerns any party or entity or another person who have a mutual interest with him/her, must declare that relationship to the Head of the Committee. If the Head of the committee is that person with the conflict of interest, he/she must declare it to the next relevant senior member who takes place in heading the meeting.

Procedure: *(See flow chart)*

1. Procedure for Faculty Board members and members of Departmental Assessment Committee

1.1 The Dean, in writing, requires each Faculty Board member; each Departmental Assessment Committee (DAC) member (via HOD); academic & joint staff; and non-academic staff to make a full disclosure on appointment, and annually before the first Faculty Board meeting of each year to the EA-FOM or to EA-Hospital (via VDHA).

1.2 The Employee Affairs submit declarations to the DFA at the beginning of each academic year

1.3 The DFA reports a list to the Dean who submits it to the FMAC

1.4 The Chair of the Faculty Main Assessment Committee (FMAC) arrange for scans of these.

1.3 The (FMAC) maintain the register of declared interests and has it available at all Faculty Board and (FMAC) meetings.

2. Procedure for annual update of all declarations

2.1 Conflicts of Interest Disclosures will be updated annually as part of the FMAC annual data verification exercise.

2.2 When there has been a change in information, staff must complete and submit a new Disclosure Form.

3. Access to conflict of interest declarations

Only authorized members of the FMAC can access these records.

Definitions:

Conflict of interest: A conflict between one's interests whether, financial, trustee or personal with any family relative of the first, second, third or fourth degree or between him/her and any person or partnership or corporation or business or other organization that might affect the interests of the institution in which he/she works in.

Fiduciary: Relating to or involving a confidence or trustee.

Recuse: Retreat from voting or judging in any case to avoid any conflict of interest.

Family and special relationships: Any family relative of first, second, third or fourth degree; current or past marital relationships, friendships, business relationships; partnerships; interpersonal conflicts.

Financial interest: means anything of monetary value, including but not limited to, salary or other payments for services.

Attachment: Disclosure Form

Document ID: ASS-I.3	Title: Assessment Process Quality Assurance		
Prepared By: VDD QAAU	**Date Prepared:** 03/06/2015		
Approved By: **CDAC** **Faculty Council** **University Board**	**Date Approved:** 3/11/2015 5/ 1/ 2016 18/ 1/ 2016		
Effective Date:			
Revision No.: --------	**Reviewed By:** --------	**Date Reviewed:** --------	**Date Next Revision:** 5 years after approval

Policy:

According to standard best practices, the medical school must have an assessment plan which secures the achievement of the school's mission. Assessment process must ensure appropriate security of exam content as an essential aspect for maintaining the integrity of the exams. The exam blueprint and all content, specifically questions and answers of the exams are the exclusive and confidential property of the course/ module coordinator.

Item analysis results must be double checked to ensure right decisions regarding alteration of students' scores.

Purpose:

1.7 Secure a validated assessment process
1.8 Protect the confidentiality and security of the exam blueprint and content.
1.9 Make right decisions when modifying students' scores based on the item analysis results

Scope:

- Course/ module director (male and female)
- Course/ module exam committee

- Educational Affairs in AU
- IT in AU
- Curriculum Unit in Medical Education Department
- Assessment Unit (AU)
- Quality & Academic Accreditation Unit (QAAU)

Responsibilities:

- **Course/ module director:**
  - Prepare the exam blueprint
  - Sign the exam blueprint and date it
  - Assign each faculty member in the course/ module committee to submit the required number of items as defined by the exam blueprint
  - Items are re-reviewed by the course coordinators for sound design according to a checklist issued by the Medical Education Department
  - Enter the items into the system (if e-exam); type and print the exam (if paper exam)
  - Submit the exam to the principal administrator on exam day
  - Submit the exam blueprint and the items categorized into recall and reasoning items ***after the exam ends*** in a closed envelop to the Quality and Academic Accreditation Unit as required documents in the course/ module folder for validation.
  - Interpret item analysis
  - Discuss and match interpretation results of item analysis done by the interpreters from the Quality and Academic Accreditation Unit, Assessment Unit and the coordinators of the course/ module to make sure of the questions that must be deleted and re-distribution of its marks.
  - Receive the final report based on item analysis and take the final decision to delete the tagged questions and amendment of the grades ***before their declaration*** to students

- **Course/ module committee:**
  - Design the exam items required by the course/ module coordinators, each according to his/her specialty
  - Review the items each in his/her specialty for sound design according to a checklist issued by the Medical Education Department
  - Submit the items in a closed envelop to the course/ module coordinators

- **Educational Affairs in AU:**
  - Prepare the exams schedules
  - Prepare the halls
  - Recruit the invigilators

- **IT in AU:**
  - Prepare computer labs in case of e-exams
  - Fix any technical problems which might occur during the exam

- **Main Faculty Assessment Committee (MFAC):**
  - Participate in putting assessment plan based on the recommended standards

- **Assessment Unit:**
  - Nurture the item bank with new items
  - Measure the psychometrics of new items before using them in summative exams.
  - Help course directors retrieve suitable items from the item bank
  - Secure marking of the exam either on using an OMR or manual marking of essay questions by formally assigned faculty
  - Send analysis simultaneously for each of: the course/ module coordinator, and Quality and Academic Accreditation Unit
  - Interpret item analysis report
  - Discuss and match interpretation results of item analysis done by the interpreters from the Quality and Academic Accreditation Unit, the coordinators of the course/ module and the psychometrician to make sure of the questions that must be deleted and re-distribution of its marks.
  - Issue a report signed by the psychometrician and Heads from the Quality and Academic Accreditation Unit, and Medical Education Department as well as the coordinators of the course/ module for accountability if necessary.

- **Curriculum Unit in Medical Education Department:**
  - Issue a checklist for reviewing items
  - Validate the checklist by references

- **Quality & Academic Accreditation Unit:**
  - Participate in putting assessment plan by providing benchmarking standards
  - Receive the exam blueprint and categorized items after the exam ends in a closed envelop

- Verify the validity by matching the submitted blueprint to the categorized items
- Interpret item analysis
- Discuss and match interpretation results of item analysis done by the psychometrician and the coordinators of the course/ module to make sure of the questions that must be deleted and re-distribution of its marks.
- Issue a report signed by the psychometrician, Heads from the Quality and Academic Accreditation Unit, and Medical Education Department as well as the coordinators of the course/ module for accountability if necessary.
- Issue a quality assurance a quality assurance verification report and discuss it with the course coordinators.
- Send the report to the Vice Dean for Development and Vice Dean for Female Section to discuss it if necessary in the Curriculum Committees and conservation into the Academic Accreditation file under the third standard.

Procedure:

No.	Responsible Person(s)	Procedure	Rationale
1	Quality & Academic Accreditation Unit	Put the assessment plan & process for the curriculum	To ensure the plan comply to the standards and secures valid reliable assessment which has an educational impact.
2	CDAC	Approves the plan in its 1st meeting in October	To ensure compliance
3	Course/ module coordinator	Prepare the exam blueprint*	To secure content validity of the exam results
4	Course/ module director	Keep the exam blueprint in a closed envelop only in their custody	To ensure security of the exam content
5	Course/ module director	Nominate faculty members in the course/ module committee to submit/ or retrieve the required number, type & level of items from item bank as defined by the	To secure sound subject matter content and that what was taught is what is intended to be assessed

		exam blueprint & each according to his/her specialty	
6	Course/ module director	Issue a written form containing the names of the nominated faculty & send it to Assessment Unit Director	
7	Assessment Unit	Supervise & support nominated faculty members retrieve items from item bank	
8	Course/ module faculty members	Review the items each in his/her specialty for sound design according to a validated checklist	To secure sound design and minimize construct irrelevant variance
9	Course/ module faculty members	- ***Theoretical & Practical/Clinical exams:*** Submit the items/stations in a closed envelop to the course/ module coordinators	To ensure security.
10	Course/ module coordinator	Review the items/stations & make sure they conform to the blueprint	To ensure security and confine accountability.
11	Course/ module coordinator	***Theoretical exam:*** In case e-exam, enter the exam in the system via the Assessment Unit or in case paper exam, print the exam & submit it to the principal administrator on exam day ***Practical/Clinical exam:*** provide the requirements of the required stations to the corresponding	To ensure security and confine accountability.

		administrator to prepare the setting	
12	Educational Affairs in AU	***Theoretical exam:*** - Prepare the exams schedules - Prepare the halls - Recruit the invigilators	To prepare an appropriate exam environment, manage it and reduce cheating
13	Clinical Assessment coordinators (CAC) in AU	Practical/Clinical exam: - Prepare the stations - Recruit simulated patients - Check the exam setting - Recruit the organizers	
14	IT in AU (e-exams)	- Prepare computer labs in case of e-exams - Remain in the vicinity of the exam halls throughout the exam duration	Fix any technical problems which might occur during the exam
15	Course/ module director	Submit the exam blueprint and the items categorized into recall and reasoning items ***after the exam ends*** in a closed envelop to the Quality and Academic Accreditation Unit as required documents in the course/ module folder for validation.	To complete the required documents in the course/ module folder for validation.
16	Quality and Academic Accreditation Unit	Receive the exam blueprint and categorized items after the exam ends in a closed envelop and signs receipt to course coordinator	To complete documentation requirements and use those documents to validate the assessment process and issue a verification report.

17	Quality and Academic Accreditation Unit	Match the submitted blueprint to the categorized items	To verify compliance to the blueprint
18	Quality and Academic Accreditation Unit	Issue a verification report - 1 and discuss it with the course directors	To verify reflection of blueprint in the exam
19	Course/ module director	Send raw item analysis report to Assessment Unit	To allow for blind interpretation of the report by psychometrician
20	Assessment Unit (Psychometrician)	Sends raw item analysis report to Quality and Academic Accreditation Unit	To allow for blind interpretation of the report by Quality and Academic Accreditation Unit
21	Course/ module director	- Interpret item analysis* - Issues a signed report - Sends report to QAAU	1st interpretation
22	Psychometrician	- Interpret item analysis -Issues a signed report - Sends report to QAAU	2nd interpretation
23	Quality and Academic Accreditation Unit	- Interpret item analysis - Issues a signed report	3rd interpretation
24	Quality and Academic Accreditation Unit & Assessment Unit & Course/ module coordinator	Discuss and match interpretation results of item analysis done by the three interpreters	To reach consensus of the questions that must be deleted and re-distribution of its marks.
25	Quality and Academic Accreditation Unit	Issue a quality assurance verification report of the assessment process for each course/module and discuss it with the course coordinators & Assessment Unit	To provide verification of compliance with the 3rd standard of the National Commission for Academic Accreditation and Assessment (NCAAA) and enhancing improvement of the assessment operations
26	Assessment Unit	- Issues & sends an annual report on assessment process to the QAAU	- To ensure consistency of data and results (independent verification) with those reached by QAAU

27	Quality and Academic Accreditation Unit	- Issues & sends a final quality assurance annual report on assessment process after independent verification and after examining the Assessment Unit report for consistency/discrepancy to the CDAC - Provides trend analysis of assessment KPIs + IAP	To complete the process required by standard (4) & conserves the report into the Academic Accreditation file under the third & fourth standard.
28	CDAC	Discusses the final annual assessment report and the trend analysis of KPIs issued by the QAAU	To discuss recommended improvement plans & take decisions for action

*** The Assessment Unit nominates educationists to help course coordinators to develop their BP and IA**

Document ID: ASS-I.4	Title: Assessment Design		
Prepared By: QAAU	**Date Prepared:** 03/6/2015		
Approved By: **CDAC** **Faculty Council** **University Board**	**Date Approved:** **3/11/2015** **5/ 1/ 2016** **18/ 1/ 2016**		
Effective Date:			
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Policy & Procedure:

4.1 Course Completion Criteria:

"The criteria that determine whether a student has completed a course will include: completion of course activities (written assignments, practical work, quizzes, examinations, presentations, interactions); and outcomes of formal summative examinations."

The course director is responsible for determining completion of these criteria by officially enrolled students.

Key for choice of assessment design criteria is alignment between course learning outcomes, teaching/learning activities and assessment tasks.

4.2 Quality Assurance of Assessment Literacy:

"All stakeholders involved in the assessment process must be provided with opportunities to develop their assessment literacy to a standard that secures their understanding of assessment as a package of interdependent processes and not an examination event."

The Dean must ensure that all stakeholders (leaders, faculty, students, and academic administration) understand assessment policies and procedures.

4.3 Eligibility for Final Examination:

"The Dean or his delegated authorities have the authority to prevent a student from attending the final course examination if the student violated the required attendance percentage of the required classes or did not submit all the required tasks."

4.4 Assessment Requirements:

"A course assessment design must follow the minimum requirements based on the time required to master the learning objectives: at least two high-stake assessment tasks that measure higher cognitive skills distributed at pre-determined milestones in the curriculum; an early low-stake assessment task that serves as a diagnostic assessment to provide feedback for both students and teachers; describe assessment tasks, their relative weights and methods of assessment and grading; clarify type and timing of feedback; describe how interaction is to be assessed and justified in relation to learning objectives."

Assessment requirements are approved by the CDAC after being discussed in the corresponding phase curriculum committees and are implemented by the course directors.

4.5 Variations to Course Assessment Requirements:

"When a variation to the assessment requirements is recommended by the course director after a course has commenced:

- The requested changes must maintain the alignment and link between the assessment methods and the intended learning outcomes
- The changes must be raised and approved by the Dean or the corresponding Vice Deans
- Variations must not disadvantage students "

4.6 Communication of the Course Specifications and Study Guide to Students:

- The course director must provide the course specifications and study guide to students through a variety of tools as the Faculty website, the Blackboard or the study guide a week before commencement of the course and make sure that all officially enrolled students are able to access it. If any variations in the course specifications occurred, the course director must make sure the all officially enrolled students have been informed.

- The course specifications and study guide must:

- Display course learning outcomes and the expected learning objectives from each topic in the course

- Include details of the assessment tasks as regards: their alignment with the learning objectives and outcomes; criteria against which assessment tasks are judged; relative weight of each assessment task; due dates of assessment tasks; grace periods allowed for late submissions; duration of assessment tasks; type and timing of feedback
- Be available in hard and electronic forms
- Show the importance of referencing and the required style

4.7 Assessment Design:

It is the responsibility of the course director to ensure that:

- An assessment plan must include the assessment continuum: include formative, intermediate and summative assessments. Feedback is an essential component of formative and intermediate assessments.

- Alignment of assessment tasks with learning outcomes and objectives is key for valid reliable results and must be checked during design and implementation of the course

- Assessment methods must be diverse and not reliant on a single form: assessment tasks must include both selection and supply type tasks; theoretical and practical/clinical tasks.

- Students must be trained on the various methods of assessment tasks.

- Assessment tasks must connect learning outcomes with real world problems.

- Assessment tasks must be developmental: cover the array of the cognitive, psychomotor and affective taxonomies; whereby the complexity in assessment tasks must reflect the level of the course.

- Appropriate valid and reliable mechanisms are used for verifying standards of student achievement *(See Policy ASS- I.3)*.

4.8 Examinations:

- ***Examinations process*** must ensure valid reliable results *(See Policy ASS- I.3)*.

- ***Repeat Questions and Equating Subtest:*** 20% of each exam consists of questions repeated from previous examinations. The purpose from repeat questions is that they constitute the "Equating Subset" for the construction of a psychometrically valid exam: determine whether an exam become harder or easier according to the psychometric analysis; adjust the passing score; and provide information

whether the examinees have become more capable or less capable. Repeat questions do not have a great effect on the results of the exam so long their discrimination index is high.

The percent of repeat questions is monitored by the Main Faculty Assessment Committee and the Quality & Academic Accreditation Unit, as an independent party, provides a report on the verification of their role in the results of the exam.

- ***Marks distribution*** must conform to the university bylaws:

- Minimum 40% for continuous assessment
- Not more than 60% for final assessment

The marks distribution in either component could be customized by the course director according to the nature of the assessment tasks and the weight of its related learning outcomes. Customization results must be approved by the Dean or corresponding Vice Deans.

In preclinical courses, continuous assessment marks are distributed by any alternative method pursued by the course director. Group assessment must be based on clear criteria and teaching staff must be aware of and trained in how to assess individual contributions to group work.

In case of clinical courses, most of the marks in either component must be allocated to the clinical assessment tasks so that passing the clinical assessment tasks is mandatory for passing the whole course.

4.9 Disposal of assessment Material:

Any assessment material must be retained by the course director/control room for at least six months after the official announcement of the course results; except material related to an appeal.

Material related to an appeal must be retained for six months after the date of the final decision of the appeal is determined.

Purpose:

1.10 Identify the responsibilities and rights of stakeholders: students, academic leaders and administration and faculty members in the implementation of the assessment process
1.11 Ensure processes are consistent with Faculty assessment policies and University bylaws
1.12 Ensure that the assessment strategies used yield fair, valid and reliable results

1.13 Secure a comprehensive integrated assessment plan throughout the curriculum to ensure achievement of its learning outcomes

1.14 Ensure quality assurance of the assessment process and outcomes

Scope:

- Dean
- Vice Deans
- The Main Faculty Assessment Committee (FMAC)
- Quality & Academic Accreditation Unit
- Course directors (male and female)

Responsibilities:

- **Dean & Vice Deans:**
  - Ensure that the policies and procedures and bylaws are committed to
  - Judges eligibility of students for final exam based on attendance and completion tasks
  - Approve variations of assessment requirements that might be raised by course directors
  - Approve customization of marks distribution that might be raised by course directors

- **Quality & Academic Accreditation Unit:**
  - Documentation of evidence of ideal practice and compliance to standards and policies
  - Provides a report on the verification of the role of repeat questions in the results of the exam

- **Course Directors:**
  - Put criteria for completing the course according to the bylaws
  - Put the assessment plan with approval of CDAC and corresponding curriculum committees
  - Recommends variations to assessment requirements after approval of Dean or his delegates from vice deans.
  - Communicate course specifications and study guide to students

  - Put the assessment design
  - Constructs examination and have the right to customize marks distribution after approval of Dean or his delegates from vice deans.

- Keeps examination material for the duration set in the policy

- **Higher Administration, FMAC and Quality & Academic Accreditation Unit:**
  - Monitor the percent of repeat questions in an exam

Procedure:

No.	Responsible Person(s)	Procedure	Rationale
1	FMAC and Quality & Academic Accreditation Unit	Put assessment policies & ensure their understanding by stakeholders	To develop assessment literacy
2	Course director	Set the completion criteria of the course	To ensure fairness of legibility to enter final exam
3	Dean & Vice Deans	prevent a student from attending the final course examination if the student violated the required completion criteria	
4	Course director	Recommends assessment requirements which covers the assessment continuum	To ensure measurement of the intended learning outcomes (secure content and construct validity)
5	Phase Curriculum Committees	Discusses the soundness and comprehensiveness of the recommended requirements	
6	CDAC	Approves the final assessment requirements	
7	Course director	Designs & Implements assessment plan according to the approved requirements	
8	Course director	Might recommend variations to the assessment requirements in the plan	To ensure validity and reliability to adapt to any encountered alterations
9	Dean & Vice deans	Approve any variations in assessment requirements	To ensure maintenance of alignment with learning outcomes
10	Course director	Provides the course specifications and study guide to students	To ensure communication of learning objectives & assessment

		through a variety of tools	tasks to students
11	Course director	Construct examination according to ideal practices in (*Policy ASS- I.3)*	To ensure validity and reliability of results
12	Course director	20% of each exam consists of questions repeated from previous examinations with known psychometrics	To ensure a psychometrically valid exam
13	FMAC & QAAU	Monitors the percent of repeat questions & issues a report	To verify the role of repeat questions in the results of the exam
14	Course director	Can customize marks distribution in final & continuous components	To match the nature of the assessment tasks and the weight of its related learning outcomes
15	Dean & Vice deans	Approve any customization to marks distribution	
16	Course director	Retains assessment material for at least six months after the official announcement of the course results	To keep evidence for any future legal claims or appeals
17	Course director	Retains material related to an appeal must for six months after the date of the final decision of the appeal is determined.	To keep evidence for any future legal claims or appeals

Document ID: ASS-I.5	Title: Summative Examination Procedure		
Prepared By: VDD QAAU	**Date Prepared:** 03/6/2015		
Approved By: **CDAC** **Faculty Council** **University Board**	**Date Approved:** **3/11/2015** **5/ 1/ 2016** **18/ 1/ 2016**		
Effective Date:			
Revision No.: --------	**Reviewed By:** --------	**Date Reviewed:** --------	**Date Next Revision** 5 years after approval

Policy:

Students must abide to the Faculty regulations concerning summative examination procedures.

Procedure:

Procedures before the Examination:

1. Corresponding vice deans and female vice dean issue and sign the final exam timetables, and send them to course directors
2. Students receive the scheduled examinations date, time and venue from the 1st day in the course.
3. Students gather before the pre-set starting time of the exam by 15 minutes.
4. Students are allowed to sit the exam if they arrive late, up to 25% of the total duration of the exam.
5. The pre-set duration of the exam is constant- no extra time provided- to students who arrive late and are allowed to sit the exam.
6. Students who arrive late more than 25% of the total duration of the exam, will score a zero mark for that exam
7. Students must show their ID to the invigilator whenever asked
8. Students must not have the following items in the examination room:

- Books
- Mobile phones or electronic devices
- Notes/ documents
- Personal items

9. Female students unveil their head cover during the exam
10. Each student signs his/her name in the attendance sheet
11. Examination answer sheets and attendance slips are kept in the control room in a confidential safe for one year after graduation; after which they are disposed of.
12. Approval from the corresponding Vice Dean is mandatory in case any exceptions are allowed.

Procedures during the Examination:

1. This time is considered part of the total duration of the exam.
2. During the exam, students must not communicate with each other for any reason
3. Answer sheets must be collected while the students are seated.

Leaving the Examination Room:

1. Students could not leave the examination room during the first three minutes of the starting time or the last ten minutes before the end of the exam.
2. The invigilator must take the answer sheet from students who decide to leave the examination room.

Breaches of Examination Procedures:

1. Breaches of examination procedures will be considered as misconduct.
2. The chief invigilator is responsible for dismissing any student who commits a misconduct during the exam, documents the incident in the standardized forms and handles the report to the corresponding Vice Dean within a week.
3. The Vice dean follows the *(Policy S- I.1)* regarding Students' Academic Honesty.
4. The chief invigilator must inform the student that the misconduct incident will be reported to the corresponding Vice Dean if he'she permits the student who showed misconduct to stay in the examination room.
5. If the Vice Dean finds that the breach does not constitute academic misconduct, the student will be provided academic counseling through the Students Support Unit (SSU).

Purpose:

1.15 Identify the responsibilities and rights of students before, during and after examination
1.16 Ensure integrity of the examination process

Scope:

- Vice Deans
- Course directors (male and female)
- Students
- Chief invigilator
- Students Support Unit

Students

S-I

Document ID: S-I.1	Title: Students' Academic Honesty		
Prepared By: QAAU	Date Prepared: 11/6/2015		
Approved By: Faculty Board University Council	Date Approved: 07/ 11/ 2016 27/ 11/ 2016		
Effective Date:			
Revision No.: --------	Reviewed By: --------	Date Reviewed: --------	Date Next Revision: --------

Policy:

Faculty of Medicine in King Abdulaziz University expects academic integrity from students. Students are responsible for any acts of academic dishonesty or cheating which include acts of plagiarism, forgery, fabrication or misrepresentation.

Purpose:

1.17 Secure a healthy academic environment
1.18 Protect the copyrights of peers
1.19 Preserve the reputation of the institution
1.20 Graduate doctors with in-built Islamic values

Scope:

- Faculty member
- Academic Review Committee
- Corresponding Vice Dean(s)
- Dean

Responsibilities:

- **Faculty members:**
  - Conducts students' orientation on academic honesty
  - Disseminates orientation material through a variety of methods: Faculty website, print material, student guidebook, and other information resources.
  - Follows this policy and procedure
  - Makes judgment whether the act of dishonesty represents a developmental need or an intentional dishonest act; informed by the student's academic history and conduct as well to the particular circumstances of the incident.
  - Raises the issue to the corresponding vice dean.

- **Vice Dean(s):**
  - Arrange for a meeting for the Academic Review Committee

- **Academic Affairs Committee:**
  - Discuss the raised incident and judgment in presence of the faculty
  - Put recommendations
  - Raise the report to the Dean

- **Dean:**

  - Issues the final decision: reprimand, warn or dismiss based on the raised report from the Academic Review Committee

Procedure:

No.	Responsible Person(s)	Procedure	Rationale
1	Faculty member	Analyze the incident informed by: - this policy and procedure - incident circumstances - student's history of academic conduct	To ensure justice to the student and make a sound objective judgment that is informed by the regulations
2		Makes a judgment of whether the incident is: - intentional, or - represents a need for development	To determine the following path of the investigation
2.1	***If the incident results from the need for development***		
	Faculty member	- Provides developmental advice to the student in relevance to the incident nature - Raises the result with the student - Familiarizes the student to the expected behavior - Guides the student to information resources concerning academic honesty	To orient the student of the regulations concerning academic honesty and informs him/her of the consequences of breaching the regulations
	Faculty member	- May ask the student to re-write the assignment in a way which demonstrates academic standards of honesty - Ask for additional assignments that require academic honesty - May lower the grade of the student in that particular assignment	To put developmental actions into application
	Faculty member	- Monitors the student closely	To ensure those incidents are not repeated
	Student	- Responsible to learn about those regulations	To avoid future incidents
2.2	***If the incident is intentional:***		

	Faculty member	- Raises the concern with the student - Allocates a zero for the particular assignment or exam - Informs the student in writing within four weeks of the decision taken and the reasons underlying it. - Copies of the written notice are raised to the corresponding vice dean(s)	-To avoid repetition of those incidents -To preserve copyrights -To establish Islamic values and sound academic conduct
	Vice Dean(s)	- Raise the incident to the Academic Review Committee - Send a written notice to the student within two working weeks	- To further discuss and examine the case to secure a just decision -To provide the student an opportunity to respond in writing to the Academic Review Committee
	Student	- If the student finds the decision unfair, s/he could raise an appeal according to the policies and procedures for students' appeals to the Academic Review Committee within two working weeks.	To secure student's rights
3	Academic Review Committee	- Reviews the case and the student's academic history and the student's appeal if any - Arrange for a hearing within four working weeks from receiving the case - Gives full time for all parties to talk and respond meaningfully to the presented case - The committee then deliberates in a closed session through a majority vote - Raises a report with the recommended action to the Dean: reprimand; warning; or dismissal; and copies to the	To further emphasize justice to the student

		student and faculty member within a working week from the hearing session	
4	Dean	- Within a working week from receiving the Academic Review Committee's report, the dean issues a decision which is either consistent to that recommended by the committee or any other decision that he sees appropriate - Provides a written notice to the student and copies to the faculty, and Academic review Committee Head showing the date of starting implementation of the decision	To ensure implementation of the institutional regulations
5	Academic Review Committee Head	- Keeps the Dean's notice in the student's file	Archiving for future appeals or reinstatements
6	Student	- Has the right to ask for reinstatement in the incident only if she/he can provide new documentations or evidences - Student has no right of reinstatement if it is the second time she/he is dismissed due to academic dishonesty act - Reinstatements are not legible after passage of one term on the dismissal decision	To secure students' rights
7	Dean	- Any reinstatement decisions are sent to the faculty member, corresponding vice dean(s) and the Academic Review Committee	

Document ID: S-I.2	**Title: Student Conduct**		
Prepared By: QAAU	**Date Prepared:** 11/6/2015		
Approved By: Faculty Board University Council	**Date Approved:** 07/ 11/ 2016 27/ 11/ 2016		
Effective Date:			
Revision No.: --------	**Reviewed By:** --------	**Date Reviewed:** --------	**Date Next Revision:** --------

Policy:

The Faculty of Medicine in King Abdulaziz University expects students to follow a responsible conduct that ensures the preservation of all members' property, respect and safety. Students also must receive the same from peers, faculty and staff.

(Regulations of the Faculty of Medicine in King Abdulaziz University for misconduct must be defined and attached to this document)

Purpose:

2.1 Defines the mutual relationship between students and the Faculty of Medicine
2.2 Determines the essential values necessary for an effective learning environment

Scope:

- Complainant(s)
- Corresponding Vice Dean(s)
- Student Conduct Committee
- Dean
- Academic Affairs Office

Responsibilities:

- **Complainant:**
  - Submits a signed, written complaint with any essential documentation to the Academic Affairs Head within four working weeks of the occurrence of the event
- **Vice Dean(s):**
  - Arrange for a meeting for the Academic Affairs Committee

- **Academic Affairs Committee:**
  - Administers formal procedures concerning students' conduct

- **Dean:**

  - Issues the final decision: expulsion or suspension based on the raised report from the Student Conduct Committee

- **Academic Affairs Office:**
  - Maintains records and provide them at any time whenever needed

Procedure:

No.	Responsible Person(s)	Procedure	Rationale
1	Head of Student Conduct Committee	- Determines if the allegation is justified - If the allegation is not justified and is not included in the scope of that policy, the Head of the Academic Affairs Committee provides the concerned student a written notification. - If the allegation lies within the scope of that policy, the Head of the Academic Affairs Committee directs it to a formal or informal pathway accordingly. - A formal pathway is pursued if the student is charged with a violation of that policy.	To determine the path of the complaint: informal or formal. The notification must include: - The identity of the complainant - Summary of the violation of the policy - Summary of the documents provided against the student - copy of the policy The notification must conclude the following pathway: an informal discussion, or referral to the Academic Affairs Committee.

		- Notifies the student in writing within two working weeks of the receipt of the complaint.	
2	***Informal Resolution:***		
	Head of Student Conduct Committee	- Addresses the issue with the student and tries to resolve the concern informally	
3	***Formal Complaints:***		
3.1	***Case does not warrant expulsion or suspension:***		
	Head of Academic Affairs Committee	- Arranges for a discussion meeting with the student	
3.2	***Case potentially warrants expulsion or suspension:***		
	Head of Academic Affairs Committee	- Refers to ***Academic Affairs Committee for a hearing***	
4	***Discussion Meeting:***		
	Head of Academic Affairs Committee	- Conducts the meeting within ten days of sending the written notification to the student - Discusses the allegation in relevance to the policy with the student - Listens to the students' defense - Makes a decision - Provides a written report to the student , the complaining person and a copy to the Dean - Keeps a copy in the records.	Decision is made to determine the path of the case later: 1. student is not responsible 2. student is responsible: 2.1 administrative resolution of the issue by mutual agreement of both parties (student & complainant) 2.2 refer student to the Academic Affairs Committee for a hearing if s/he finds the case warrants expulsion or suspension 2.3 issues a written warning is appropriate
5	***Student Conduct Committee Hearing:***		
	Head of Academic Affairs Committee	- Assigns a head for the hearing session - Takes place within four working weeks of the referral - Conducts a fair hearing which is evidence-based - Obtains any documents necessary for supporting the	

		allegation against or with the student	
	Complainant & the student	- Have the right to ask for witnesses - Have the right to refuse to answer some questions	
	Student Conduct Committee Member	- Records the hearing either in writing or using a record after taking permission from the attendees	
	Student Conduct Committee	- Makes a decision in a closed session - Provides a written report to the student , the complaining person and a copy to the Dean.	The decision could be: 1. student is not responsible 2. student is responsible: 2.1 refers the case to the Head of the Academic Affairs Committee for reconsideration through a discussion meeting 2.2 finds the case warrants expulsion or suspension or issues a written warning
	Head of Student Conduct Committee	- Implements the decided penalty within five days of the Academic Affairs Committee's decision.	
	Student	- Could raise a written appeal against the Academic Affairs Committee decision with justifications to the Dean.	
	Dean	- Sends a written notification to other parties involved in the case within five days from receiving the appeal.	
	Involved parties	- A written response by other involved parties is sent to the Dean within ten days	
	Dean	- Provides a written decision within five days after receiving the responses to the student's appeal.	
	Academic Affairs Office	- Maintains records of appeal incidents for the five years following graduation. In case	To maintain records for later legal actions

		suspension or expulsion occur, records are maintained indefinitely for any future legal claims	

Document ID: S-I.3	Title: Student's Appeal for Academic Issues		
Prepared By: QAAU	Date Prepared: 11/6/2015		
Approved By: Faculty Board University Council	Date Approved: 07/ 11/ 2016 27/ 11/ 2016		
Effective Date:			
Revision No.: --------	Reviewed By: --------	Date Reviewed: --------	Date Next Revision: --------

Policy:

Resolution of students' complaints of academic decisions is the responsibility of the department involved and must be done by experts in the particular academic discipline.

The Faculty of Medicine in King Abdulaziz University follows the procedures that are pre-set by the University for students' appeals to academic issues.

Purpose:

3.1 Preserve student's rights

3.2 Maintain the trust between the student and the institution regarding learning outcomes and evaluations

Scope:

- Student
- Student Support Unit
- Corresponding Vice Dean(s)
- Academic Review Committee
- Dean
- Vice President for Academic Affairs
- President
- Academic Affairs Office

Responsibilities:

- **Student:**
  - Submits a signed, written appeal with any essential documentation to the Academic Affairs Head within four working weeks of the occurrence of the event

- **Student Support Unit:**
  - Conducts an informal discussion with the student to clarify the issue and to reach a resolution before proceeding to a formal complaint pathway.

- **Vice Dean(s):**
  - Arrange for a meeting for the Academic Review Committee
  - Issue a written decision

- **Academic Affairs Committee:**
  - Administers formal student's appeal procedures

- **Dean:**
  - Appoints an advisory panel to investigate the corresponding Vice Dean's decision in case the student raises an appeal on it.
  - Issues a decision to the student in writing

- **Vice President for Academic Affairs:**
  - Investigates the Dean's decision in case the student raises an appeal on it
  - Issues a written decision
- **President:**
  - Issues a written decision

- **Academic Affairs Office:**
  - Maintains records and provides them at any time whenever needed

Procedure:

No.	Responsible Person(s)	Procedure	Rationale
1	***Informal Resolution:***		
	Student	- Discusses the issue with the instructor who took the decision within ten days from receiving it	To maintain a smooth trustful relation between students and faculty
	Student Support Unit	- Conducts a discussion with the faculty to reach a resolution before proceeding to a formal complaint pathway	
	Vice Dean	- If the student's initial attempt to resolve the issue informally with the faculty fails, the vice dean addresses the issue with the student and facilitates the resolution of the concern informally; this occurs within two working weeks from receiving the academic decision	To facilitate a resolution when possible; she/he does not play a decision-making role
2	***Formal Complaints:***		
	Student	- Submits a written appeal to the Vice Dean. *Any complaint raised by the student later than the semester that immediately follows the semester in which the incident happened, will not be considered.*	The student's complaint must contain: (a) the specific action or decision that constituted the appeal; (b) the effect of that action or decision on the student's academic or social future; (c) the actions taken to reach a resolution; (d) current contact information
	Vice Dean	- Issues a written decision. - In the latter case, s/he sends the appeal to the Academic Affairs Committee - Provides a copy to the relevant faculty member and Head of Department or Course Director	

	Academic Affairs Committee	- Checks any unfair decision falling on the student and checks any improper application of the relevant policies. - Ensures a fair and timely hearing of the information within two working weeks from receiving the appeal request - Produces an accurate record of the hearing. - Decisions are taken in a closed confidential session. - Decisions are reached in case the majority of the Committee votes for it. - The final decision is to be delivered in writing to the students and the involved parties within five days from its issuing.	
3	***Further Appeal:***		
	Student	- May appeal the Vice Dean's decision within two working weeks, in writing, to the Dean	In all cases of further appeal the student must clearly explain the justification for further appeal.
	Dean	- Appoints an advisory panel	
	Advisory panel	- Examines the provided documents and issues a recommendation to the Dean	
	Dean	- Issues a written decision within ten days of receiving the appeal.	
	Student	- May appeal the Dean's decision to the Vice President for Academic Affairs, in writing, within two working weeks of being notified of the Dean's decision	
	Vice President for Academic Affairs	- Issues a written decision within twenty days of receiving the appeal.	
	Student	- Can raise a written appeal to the President on the Vice President's decision within 10 days from notification	

	President	- Issues a written decision within twenty days of receiving the appeal.	

Document ID: S-I.4	**Title: Student's Appeal for Final Course Grades**		
Prepared By: QAAU	**Date Prepared:** 11/6/2015		
Approved By: Faculty Board University Council	**Date Approved:** 07/ 11/ 2016 27/ 11/ 2016		
Effective Date:			
Revision No.: --------	**Reviewed By:** --------	**Date Reviewed:** --------	**Date Next Revision:** --------

Policy:

The Faculty of Medicine in King Abdulaziz University expects faculty to follow the specified grading criteria equitably to the academic performance of all students in the course regardless of their race, color, creed, national origin, sex, age, sexual orientation, disability, or other personal characteristics. Students are given the opportunity to obtain fair and impartial evaluation of their academic performance that is consistent with the standards and procedures for evaluation established by the institution.

Purpose:

4.1 Set a standardized procedure for appeals on final grades

4.2 Preserve the students' rights for fair evaluation of their academic performance.

Scope:

- Student
- Faculty
- Corresponding Vice Dean(s)
- Academic Review Committee
- Dean
- Grade Review Committee
- Deanship for Students' Affairs

- Deanship for Admissions and Registration
- President
- Academic Affairs Administration

Responsibilities:

- **Faculty:**
  - Specify at the beginning of the academic term the:
  i. Course assessment plan
  ii. Course requirements and expectations for academic performance;
  iii. Methods of assessment and grading rubrics
  - Communicate clearly to all students any subsequent changes in these requirements, expected performance levels and procedures
  - Standardized grading criteria is applied to all students in an equal manner.

- **Student:**
  - know and adhere to the institution policies

- **Vice Dean(s):**
  - Arrange for a meeting for the Academic Review Committee
  - Provide a written decision to the students

- **Academic Affairs Committee:**
  - Administers formal student's appeal procedures
  - Calls for an ad hoc grade review committee

- **Dean:**
  - Appoints a Grade Review Committee to review the student's appeal
  - Makes a decision and communicates it to the student

- **Deanship for Academic Affairs & Deanship for Registration and Admissions:**
  - Reviews the student's appeal to the Dean's decision
  - Issues a decision to the student in writing

- **President:**
  - Reviews the student's appeal to the Vice President's decision
  - Issues a decision to the student in writing

- **Academic Affairs Office:**
  - Maintains records and provides them at any time whenever needed

Procedure:

No.	Responsible Person(s)	Procedure	Rationale
1	***Informal Resolution:***		
	Student	- Discusses the issue directly with the faculty who assigned the grade immediately after receiving the formal grade in order to clarify the basis of the reported grade.	To gain understanding about the basis of his/her grade
	Student Support Unit	- Conducts an informal discussion with the student to clarify the issue and to reach a resolution before proceeding to a formal complaint pathway.	
2	***Formal Complaints:***		
	Student	- Submits a written request for review of the course grade to the corresponding vice dean within three working days of the beginning of the academic semester that follows the semester in which the final grade was submitted by Department Chair or Module Director.	The appeal must describe: - the precise reason - Relevant information must be attached to the appeal. - Any evidences as papers, syllabi or written documents that might support the student's appeal case must be provided.
	Vice Dean	- Provides a decision in writing to the student, whether to resolve it informally or refer it to the Academic Review Committee, within two working weeks of the receipt of the complaint. - In the latter case, s/he sends the appeal to the Academic Review Committee - Provides a copy to the relevant faculty member and Head of	The appeal is only accepted if: - The instructor failed to follow the pre-set course evaluation standards and grading criteria - If the grade resulted from incorrect calculations or recording. ***When the student disagrees with the assigned grade, this does not constitute a basis for a review.***

		Department or Course Director	
	Academic Review Committee	- ***If the committee sees that the allegations are true***, it requests the formation of an ad hoc Grades Review Committee within two working weeks of receiving the appeal request from the vice dean - ***If the committee sees the allegations do not constitute a violation***, then the grade review is dismissed. - The committee provides student with a written decision within three days from receiving the decision from the Grade Review Committee.	The ad hoc Grade Review Committee consists of three faculty appointed by the Dean.
	Grade Review Committee	- Determines the validity of the evidences that support the allegation - May request oral presentations from both parties - Decisions are by majority vote - Issues a decision and handles it within two working weeks from receiving the request to the Head of the Academic Review Committee.	- It is not the function of the committee to reevaluate the student's work. - If the committee's report shows that the grades were determined in an incorrect manner, a recommended action could include: *- Replacing the originally assigned grade with a new or* *- Implementation of some process to reevaluate the student's work.*
	Head of the Academic Review Committee	- Sends the report to the Dean as early as possible	
	Dean	- Makes a final decision -Communicates the decision in writing to the student, faculty member, and the Department Chair	

	Student	- Appeals this decision by the Academic Review Committee within two working weeks to the Dean	
	Dean	- Issues a decision to the student in writing, within two working weeks of the receipt of the appeal.	
3	***Further Appeal:***		
	Student	- May appeal the Dean's decision to the Vice President for Academic Affairs, in writing, within two working weeks of being notified of the Dean's decision	
	Vice President for Academic Affairs	- Issues a decision to the student, in writing within four working weeks of receiving the appeal.	
	Student	- May appeal the Vice President's decision to the President, in writing, within two working weeks of being notified of the Vice President's decision	
	President	- Issues a decision to the student, in writing within four working weeks of receiving the appeal.	

Quality Assurance

QA-I

Document ID: QA-I *QAE- I* *QAR- I* *QAI- I*	**Title: Internal Quality Assurance System of Educational Program** ***Quality Assurance of Evaluation of Educational Program*** ***Quality Assurance of Review of Educational Program*** ***Quality Assurance of Implementation of Educational Program***		
Prepared By: QAAU	**Date Prepared:** 26/4/2016		
Approved By: **Faculty Board** **University Council**	**Date Approved:** 07/ 11/ 2016 27/ 11/ 2016		
Effective Date:			
Revision No.: --------	**Reviewed By:** --------	**Date Reviewed:** --------	**Date Next Revision:** --------

Policy (QAE- I):

The institution must have an internal quality assurance management system that is committed to perform sustainable comprehensive evaluation of its institutional capacity, and educational effectiveness.

Sub-policy (QAE-I.1):

The unit responsible for managing quality is one of the important organizing units in the institution, so that it takes over the tasks of continuous self evaluation to either its institutional capacity or its educational effectiveness. It plays an important role in distributing the quality culture among the institutional personnel and in developing faculty and administrative departments as regards management of quality systems. The academic leadership in the institution must provide all forms of financial and moral support to this unit.

Sub-policy (QAE-I.2):

The Quality & Academic Accreditation Unit must play an effective role in the evaluation of institutional performance. The institution must emphasize that: this evaluation is conducted regularly; involvement

of concerned stakeholders; communicating the evaluation results; and analyzing trend by internal and external benchmarking of performance values over periods of time.

Sub-policy (QAE-I.3):

The institution utilizes the appropriate methods for comprehensive evaluation of the elements of its educational effectiveness. The results of evaluation must be discussed with academic leadership and beneficiaries in order to put enhancement and improvement action plans. Plans must be timed, monitored and measured by using objective key performance indicators.

Sub-policy (QAE-I.4):

As a crucial pillar for accountability, the institution is committed as part of its internal quality assurance system to review and operationalize the bylaws, guidelines and policies related to accountability to educational effectiveness.

Purpose:

1. To define the areas of strength and developing them, as well as areas which require improvement and amending them
2. To utilize the evaluation results in developing institutional performance

Scope:

- Quality & Academic Accreditation Unit

- Academic leadership

- Curriculum Committees

- Faculty members

- Administrative departments & offices

Responsibilities:

Of each party mentioned in the scope

Procedure:

I. At the Course Level:

I.1 Indirect evaluation of learning opportunities: At the end of the course,

1. Two surveys in the form of questionnaires have to be distributed to students:
- 1st survey evaluates students' satisfaction of the curriculum, teaching staff, continuous assessment and feedback, and learning resources (distributed at the end of instruction before the final exam by ten days).
- 2nd survey evaluates students' satisfaction of the final exam (distributed after the final exam)

2. Two surveys in the form of questionnaires have to be distributed to the teaching staff:
- 1st survey evaluates faculty's' satisfaction of the course
- 2nd survey evaluates faculty's satisfaction of the final exam (distributed after the final exam)

I.2 Indirect evaluation of students' perception of acquiring the learning outcomes: One survey in the form of questionnaire that contains the course learning outcomes (CLOs) per domain has to be distributed to students at the end of the course before the final exam by ten days.

I.3 Direct evaluation of students' achievement of learning outcomes:

1. Standardized key performance indicators for each course must be determined and benchmarked with the values in the previous years. The trend of performance is indicated and interpreted based on evidences of ideal assessment practices. These indicators are:
- Completion rate
- Success rate
- Grade distribution

2. The CLOs actual achievement is tabulated, whereby the actual achievement of each CLO is calculated from the students' scores in various assessment events. Then the actual achievement score is compared to the target values expected from students to determine whether the students met, exceeded or unmet the target.

I.4 Overall evaluation of the inputs, processes and outcomes of the course: In the pre-clinical and clinical phase curriculum committees:

- The standardized "Demo" that was designed by the Quality & Academic Accreditation Unit has to be prepared by the course director. It contains all the components of the course report.
- The course director presents the "Demo" in the departmental or module committee meeting
- The course director then presents the "Demo" in the corresponding phase curriculum committee.

I.5 Issuing of the course report:

1. The Quality & Academic Accreditation Unit issues two reports per course and sends them to the course director, course coordinator, corresponding vice dean and female campus vice dean. These are:
- 1st is a report on the surveys' results
- 2nd is an assessment verification report which evaluates and interprets the processes, and outcomes of assessment
2. The course director and coordinator utilize the results in both reports to issue the annual course report which shows an improvement action plan informed by the evaluation and assessment results. It also contains the extent of achievement of the action plan from the previous year.
3. The course director, coordinator, corresponding Vice Deans sign the course report. The course director then sends the report to the Quality & Academic Accreditation Unit.
4. The Quality & Academic Accreditation Unit reviews the report, updates statistical charts and database, and saves it in the course file.

II. At the Program Level:

II.1 Graduates' survey:

1. The Vice Dean for Clinical Affairs is committed to urge all graduates fill a questionnaire about the whole learning experience after ending the internship year.

II.2 Competences Achievement survey:

1. The Vice Dean for Clinical Affairs is committed to urge all graduates fill a questionnaire about their perception of acquiring the expected competences after ending the internship year.

II.3 Interns' survey:

1. The Vice Dean for Clinical Affairs is committed to urge all graduates fill a questionnaire about their satisfaction of the internship year experience after ending the internship year.

2. The Quality & Academic Accreditation Unit analyzes the three questionnaires, interprets the results, benchmarks the results to the previous year, determines the trend, and sends the report to the Vice Dean for Development.

II.4 Quality & Academic Accreditation Unit Program Report:

1. Informed by the results of all the previous surveys, the Quality & Academic Accreditation Unit issues a quality assurance annual report on the program
2. The Quality & Academic Accreditation Unit sends the report to the Vice Dean for Development.
3. The report is discussed in the Vice Deans' Consultancy Committee presided by the Dean, then presented in the Main Curriculum Committee (Committee for Development of Academic Curricula- CDAC).
4. Decisions are taken informed by the results in the report triangulated by other quality assurance reports.

II.5 Standardized Annual Program Report & Program KPIs:

1. Informed by the aforementioned reports at the course and program levels, the Quality & Academic Accreditation Unit issues the standardized annual program report with its KPIs cards.
2. KPIs are internally and externally benchmarked and matched to its target benchmark.
3. KPIs values triangulated with the results of the quality assurance reports at the course and program levels are used to spot the points of strength and the challenges and are utilized to put an informed improvement or developmental action plan.
4. The QAAU issues a cohort actual PLOs achievement matrix which presents the actual achievement of each PLO by utilizing the CLOs achievement matrices for each course during that cohort.
5. The Vice Deanship for Development discusses the report results in the Permanent Consultancy Committee of the program (PCC), CDAC and the Faculty Board at the beginning of the following academic year.

II.6 Long-term Retrospective Program Report:

1. Every complete cycle of the program, the Quality & Academic Accreditation Unit performs comprehensive evaluation using the results of the annual program reports and structured interviews which have to be conducted with the course and module committees.
2. Based on the evaluation results, the CDAC together with stakeholders-[faculty, students, heads of departments and module committees, phase curriculum committees, program consultancy committee (external stakeholder)]- decide minor or major changes in the curriculum.
3. The changes must be justified evidenced by the evaluation results.
4. The Dean Sends the modified curriculum plan with the justifications form to the Curriculum Unit in the University and similarly sends the program and course specifications sent to the Academic Accreditation Administration in the University; in order to approve the modifications.

III. At the Institutional Level:

III.1 Faculty Annual Report (FAR):

1. The Quality & Academic Accreditation Unit measures the institutional performance against the eleven standards set by the National Commission for Academic Accreditation & Assessment (NCAAA) by using their Self-Evaluation Scale (SES).
2. The Quality & Academic Accreditation Unit updates the KPIs
3. The results are internally benchmarked with those of the previous year and change rates analyzed.
4. A monitoring table of the improvement action plan (IAP) of the previous year is included to the report.
5. The results are to be reported to the academic leaders who discuss them in the Vice deans' Consultancy Committee presided by the Dean.
6. The Quality & Academic Accreditation Unit, enlightened by the results of the SES, sets an IAP to the following year and issues a FAR.
7. The report is raised to the Vice Deanship for Development and academic leaders.

III.2 Self Study Report Every Complete Cycle of Accreditation (SSR):

1. Every six years, the Quality & Academic Accreditation Unit conducts a comprehensive evaluation of the program using the NCAAA- SES, under the auspice of the Vice Deanship of development.
2. The Dean establishes: a Main Task Force Committee, an Executive Committee and Subcommittees.
3. The Quality & Academic Accreditation Unit makes orientation to all subcommittees, provides data, evidences and support to all subcommittees.
4. The Quality & Academic Accreditation Unit utilizes the reports of the subcommittees and issues a draft of the SSR
5. The Executive Committee reviews the SSR and approves the final version
6. The SSR is then raised to the Dean
7. The SSR is then communicated to the stakeholders in the institution.
8. The Faculty Board approves the SSR
9. The Dean sends the SSR to the Vice Presidency for Quality & Development that sends the SSR to the NCAAA applying for a site visit.

Procedure/ Rationale (QAE-I):

No.	Responsible Person(s)	Procedure	Rationale
1	QAAU	- Sends the blank surveys to the course director & coordinator two weeks before the end of the course in the assigned timing (see above) - Sends list of assessment requirements	Reminder for the timing and criteria of evaluation of courses by students and faculty
2	Student leaders	Distribute surveys to students in the assigned timing	Raise awareness of students and faculty of the importance of evaluation
3	Course director/ coordinator	Distribute surveys to faculty at the end of the course	
4	Course director/ coordinator	Sends filled surveys to QAAU	For analysis
5	QAAU	- Enters data	The report:

		- Analyzes data - Issues a report - Sends the report to the: * course director/coordinator * corresponding vice dean & female vice dean	* defines areas which require improvement or further development * acts as a guide to the improvement action plan
6	Course director/ coordinator	- Sends assessment requirements to QAAU: * assessment plan * copy of exam blueprint * item analysis reports * sample of students' tasks * Categorized scores * CLOs achievement table	Reminder for the documents required to assess the soundness and completeness of assessment processes and outcomes
7	QAAU	- Analyzes the assessment documents - Issues an assessment verification report - Sends the report to the course director/ coordinator & to corresponding vice deans	The report represents an independent verification process of students' achievement
8	Course director/ coordinator	- Discuss the surveys & assessment verification reports in the departmental meeting or module committees - Use the results in the reports in issuing the:	- Setting improvement plans informed by both direct & indirect evaluation results.

		* annual course report * improvement action plan * course KPIs: ➢ Completion rate ➢ Success rate ➢ Grades distribution * Actual achievement of each CLO & matching each to the intended target value - Sign course report & take corresponding vice dean's signature - Send course report to the QAAU	
9	QAAU	- Checks extent of implementation of the improvement plan of the previous year - Checks soundness & completion of course report	To ensure effectiveness, continuity & sustainability of quality assurance of curricula.
10	QAAU	- Sends a standardized demo to course director/ coordinator	Render evaluation results into meaningful information
11	Course director/ coordinator	- Prepares the demo which displays: * Basic information of the course * Course performance indicators * CLOs achievement table * Evidences of validity & reliability of results	Communication of the annual evaluation results and achievements of courses

		* Obstacles & recommended solutions * Fulfillment of quality assurance requirements	
12	Corresponding vice deans	- Present the results of the courses demos in the CDAC	Communicate results to the higher academic leaders for decision taking
13	QAAU	- Examines course reports, evaluation results, achievement reports - Issues a quality assurance program report - Sends report to academic leaders - Presents report in the Vice deans' consultancy committee	Crystallize & filter critical evaluation results to inform academic leaders to take right decisions regarding improvement of curriculum.
14	Vice deans' consultancy committee	Concludes critical issues for discussion & decision taking in the CDAC	
15	QAAU	Sends graduates' & interns' surveys to the Vice dean for Clinical Affairs Office	Collect data from graduates & interns
16	Vice dean for Clinical Affairs Office	Sends filled graduates' & interns' surveys to QAAU	In preparation for analysis
17	QAAU	- Perform steps for issuing the annual program report: * Analyzes graduates' surveys & issues the results in a report * Fills self evaluation scale for standard-4 * Completes program matrix in terms of calculating actual achievement of each PLO, domain	Preparation for issuing the annual program report

		& matching them to the intended target. * Assessing PLOs KPIs	
18	QAAU	Sends program report to Vice Dean for Development	Communicates results to academic leadership
19	Vice Dean for Development	Raises the report to Vice deans' Consultancy Committee for discussion	
20	QAAU	Presents program report in the Faculty Board	Communicates results to stakeholders (HODs & students representatives)
In Parallel			
21	QAAU	- Perform institutional evaluation by filling self evaluation scales (SES) for the 11 NCAAA standards - Issues a Faculty Annual report which contains: * SES benchmarked to the evaluation of the previous year * New improvement action plan * Monitored previous action plan - Sends report to Vice Dean for Development who raises the report for discussion in the Vice deans' Consultancy Committee	To close the loop of the quality assurance cycle
After one complete cycle			
22	QAAU	Conducts a comprehensive evaluation of the program using the NCAAA- SES	Applying for accreditation
23	Dean	Establishes a Main Task Force Committee, an Executive Committee and Subcommittees	
24	QAAU	- Makes orientation to all subcommittees, provides data,	

		evidences and support to all subcommittees. - Utilizes the reports of the subcommittees and issues a draft of the SSR	
25	Executive Committee	Reviews the SSR and approves the final version	
26	Vice Dean for Development	Raises the SSR to the Dean	
27	Dean	Communicates the results to all stakeholders	
28	Faculty Board	Approves SSR	
29	Dean	Sends the SSR to the Vice Presidency for Quality & Development	
30	Vice Presidency for Quality & Development	Sends the SSR to the NCAAA applying for a site visit	

Forms:

1. Survey that evaluates students' satisfaction of the curriculum, teaching staff, continuous assessment and feedback, and learning resources
2. Survey that evaluates students' satisfaction of the final exam
3. Survey that evaluates faculty's satisfaction of the course
4. Survey that evaluates faculty's satisfaction of the final exam
5. Survey that evaluates students' perception of acquiring the learning outcomes
6. CLOs actual achievement/ target values Table
7. Standardized "Demo"
8. Graduates' survey
9. Competences Achievement survey
10. Interns' survey

Policy (QAR- I):

The Faculty of Medicine ensures the periodic review of its academic programs. This review will be carried out every complete cycle of each program. This periodic review is to be implemented in accordance with KAU standards and requirements, and also with the requirements of the NCAAA in the Kingdom of Saudi Arabia.

See KAU Curriculum Unit policies & procedures at

http://curriculum-unit.kau.edu.sa/Pages-Policies-and-Procedures.aspx

Sub-policy (QAR-I.1):

Any changes in academic curricula at the level of courses within a program must be presented, discussed and approved by the corresponding Phase Curriculum Committee.

- ***Minor Changes:*** are changes that include adding topics that do not interfere with cultural, political or social beliefs and values; modifying CLOs or SLOs in way that does not interfere with the general objective/purpose of the course; developing teaching & assessment methods within the framework set in the program specifications and according to the available resources to ensure they achieve the purpose of using them.
  These changes are approved within departments or module committees only.

- ***In case minor changes interfere with cultural/social/political/religious values & beliefs:*** the suggested change must be discussed thoroughly in the corresponding Phase Curriculum Committee and also must be approved by the CDAC and Faculty Board.

- ***Major Changes:*** are changes that include changing credit points of a course; changing the teaching/assessment strategies radically; separating a unit to become a separate course. These changes must follow the procedures set by the KAU Curriculum Unit at

http://curriculum-unit.kau.edu.sa/Pages-Policies-and-Procedures.aspx

Procedure for Sub-policy (QAR-I.1):

- **Minor changes that interfere with cultural/political/social/religious values & beliefs:**

No.	Responsible Person(s)	Procedure	Rationale
1	Course/module committee	- Discusses the proposed changes with justifications and evaluation evidence - Sends recommendations to the corresponding vice dean	To ensure that changes are informed and evidence-based
2	Vice Dean	Raises the recommendations to the Vice Deans Consultancy Committee for discussion at the level of academic leaders	To make a preliminary decision for approval or rejection based on university bylaws and political vision in KSA
3	Phase 1 & 2 Curriculum Committees	Discusses the recommendations	
In case the preliminary decision is "approval"			
4	Committee for Development of Academic Curricula & Faculty Council	Approve & ratify the recommended change	To validate use of policies and ensure commitment and accountability

- **Minor changes that do not interfere with cultural/political/social/religious values & beliefs:**

No.	Responsible Person(s)	Procedure	Rationale
1	Course/module committee	- Discusses the proposed changes with justifications and evaluation evidence - Sends recommendations to the corresponding vice dean for informing	To ensure that changes are informed and evidence-based
2	Vice Dean	Accepts the suggested changes	Be informed of the updates in the courses & modules

Internship

INT-I

Document ID: INT-I.1	**Title: Responsibilities in Field Experience for the Internship Training Program**		
Prepared By: Interns' Office	**Date Prepared:** 31/3/2014		
Approved By: Faculty Board University Council	**Date Approved:** 07/ 11/ 2016 27/ 11/ 2016		
Effective Date:			
Revision No.: --------	**Reviewed By:** --------	**Date Reviewed:** --------	**Date Next Revision:** --------

Sub-policy (INT-I.1): Designation of Most Responsible Physician

There shall always be one physician designated the most responsible physician for every patient to ensure continuity of care and appropriate monitoring. The MRP shall be of consultant status, with admission privileges. At KAUH, it is the responsibility of the MRP and/or the supervisor to ensure that patients are provided with the name of the MRP, along with an explanation that the MRP is responsible for directing and managing their care.

Sub-policy (INT-I.2): Rotation Guidelines

1. **Rotation**:
   a. FIRST PRIORITY is to complete KAUH interns' allocations before sending others to affiliated hospitals.
   b. Under no circumstances, if needed in the University anytime to pull out interns assigned in other hospitals.
   c. **NO CHANGE OF YOUR APPROVED INTERN'S SCHEDULE.**
   d. All rotation must start on the 1st day of Gregorian month. No exception is allowed.
   e. All rotations must be 1 complete month. No splitting will be allowed under any circumstances.

f. Major rotations must be taken in 2 consecutive months, no splitting is allowed under any circumstances. Major rotation must be taken as general rotation and sub-specialties are not allowed to be chosen unless it was scheduled by the department as internal arrangement.

2. **The INTERNSHIP OFFICE is responsible in sending letters to affiliated hospital. It is NOT ALLOWED to CHANGE** the intern rotation once the letter has been sent.
3. **Interns are NOT allowed to communicate directly to the heads of department &/or affiliated hospital regarding acceptance, it is always thru the Internship office. You can communicate directly if it is being instructed by the Internship office.**
4. **Elective** must be requested at least 2 to 3 months in advance to have time for approval especially those requesting outside KAUH.
5. **Vacation** is maximum of 15 days for the whole year. (Please see the vacation policy)
6. **Exams, Symposiums, Courses etc.** are **NOT** part of the internship training. (***Interns may be required to repeat the days they missed***) There is **NO Academic leave** during internship training.
7. **Eid Holiday: Interns are only entitled to 5 days leave, which is taken either in Ramadan or Hajj Holiday only.** Interns assigned in other hospital should follow the rules and regulations of the hospital.
8. **Sick Leave**: Interns must inform immediately the assigned department and submit a sick leave report for approval. The sick leave report should be generated from a governmental hospital and preferably from the hospital where the intern is taking his/her rotation.
9. **Absences**: In case of any absences an excuse letter with documentation (if available) should be submitted in advance (if possible) to the department or maximum of within 4 working days after the absence day. The maximum legitimate days of absences from the rotations are :
    a. 5 days from 1 month rotation or 15% of the rotation which one is less
    b. 7 days from 2 months rotations or 15% of the rotation which one is less

    If any official excused absence exceed these numbers, **ALL** missing days should be repeated after the whole internship training.

10. **On-Call & Duties:** Interns are not allowed to leave the hospital while on duty, especially if On-call. Duty time & On-call should follow the department rules but minimal of 45 working hours/week must maintained. Number of On-call days should not exceed 10 days/month. The interns are allowed to leave the hospital after 12:00 noon on next day after proper endorsement and taking permission from the team.

11. **Maternity Leave**: It is preferable to make the expected date of delivery during the one month rotation. Maternity leave is considered a legitimate absence and usually last for a month. The intern must inform the internship office about her expected day of delivery as soon as she knows it. She must submit a request for the maternal leave with documentation so the internship office will make the necessary arrangement. If delivery happened or schedule is different time than the expected date, the intern must inform the internship office immediately. Any delay in notification will be under the responsibility of the intern herself for any consequences. If the intern does wish to extend her leave, she must request that officially with proper documentation.
12. **Evaluation**: We are using a 360 degree evaluation forms for all rotations. The forms are sent directly to the departments however for affiliated hospitals some needs to be carried by the interns to them. The interns are responsible to fulfill all criteria that set by the department in order to get his/her evaluation. These includes but limited to the following:
    a. Perform Formal Clearance from the hospital
    b. Retrieving any belongings
    c. Repeating any missing days
    d. Reporting to the Training/Academic Affairs

    Even if the intern had the passing score of 60%, the evaluator still can recommend some repetition of the intern's rotation according to the department's judgment.
13. The intern must follow-up his/her evaluation with the department secretary however the evaluation must be send to the internship office directly from the department. In special circumstances in which the department was unable to send the evaluation directly to the internship office, the intern must bring his/her evaluation personally to the internship office in stamped and sealed envelope.
14. The interns will not receive his/her certificate unless he/she complete all requirements (please refer to the Issuing Internship Certificate Policy).
15. **Duration of the Training:** The intern must complete all rotation and requirements within the given period that is equal to 1 full Gregorian year. The repetition of a rotation should be done after the 1-year internship training at the nearest available time. However, all repetition must be approved by the internship office. Moreover, the maximum extended time for completing the internship training is 6 months after that the intern is subjected to repeat the whole year including a pre-training exam & interview.

16. All submitted requests will be subjected for approval & final schedule can differ completely from the original requests.
17. It is expected to have 1 major rotation in KAUH.
18. Requests for changes that have legitimate reason(s) and all necessary documentation will not be accepted within the last month of the rotation.

    N.B. legitimate reasons does not include social or academic. All reasons must be accompanied by official documentation

19. **Pager: Pager MUST be answered immediately.**
20. **Interns are NOT AUTHORIZED** to sign birth certificates and all sick leaves.
21. **RESPECT your Colleague & Supervisor. (Discipline in dealing with colleagues).**
22. **SMOKING** is **NOT ALLOWED IN THE HOSPITAL** and the rest of University compound.
23. All procedure must be directly supervised by eligible staff, after the correct consent from the patient, failure to this can lead to disciplinary action which can lead to expulsion from the training program. The procedure includes:
    - IV/IM injection for regular medication NOT chemotherapy
    - Extract blood for routine blood works & blood culture
    - Urine catheter for low risk patient. NOT with coagulopathy – lady with circumcision-single lady
    - Apply CTG
    - Conducting SVD for low risk patient (with resident supervision)
    - Check fetal heart by doppler
    - Check vital signs for stable patient
    - Pap smear & endo. Sample (with Resident supervision)
    - Speculum exam & amniosure test
    - HVS (high vaginal swab)
    - Apply ECG leads
    - Nasogastric tube insertion
    - ABG
24. Failure to follow the above rules, not notified absences or conviction with an ethical situation is subjected to be expelled from the program.
25. **Dress Code**

    25.1 Dress

    a. Identification badges must be worn at all times.

b. Identification badges are to be clearly visible, above the waist.
c. The Lanyard must not interfere with patient care and safety and kept clean.
d. Identification badge holders may be worn if not interfering with patient care and safety

25.2 Hair

For men, must be clean, neatly groomed and controlled.

a. Long hair must be secured away from the face.
b. Extreme styles and colors are not permitted.
c. Fashion head bands or skullcaps are not permitted.

For ladies, must be covered as per the Shariaa law:

a. Head scarves shall not interfere with patient care and safety
b. Scarves shall not be loose for modesty and safety
c. Bright colors and glittery designs are not acceptable
d. Black, white or neutral colors shall be used

25.3 Nails must be short, neat and clean, to avoid irritating patients during clinical examination.

a. Nail polish and decorative designs are prohibited.
b. **Artificial fingernails are NOT allowed** for all staff and students in contact with patients.

25.4 Jewelry must be plain and inconspicuous.

a. Jewelry must not interfere with patient care or safety.
b. Necklaces are **NOT** permitted.
c. Bracelets or armbands **are not permitted** unless they are a Medical Alert bracelet.
d. Only one ring or ring set is allowed.
e. Well- fitting, not loose, wrist watch is permitted.
f. Facial piercing jewelry (i.e. eyebrow, nose, tongue, lip, etc.) **is prohibited.**
   Exception: If a nose ring is worn for religious/cultural purposes.

25.5 Fragrance is not to be used in the hospital and patient care areas.

25.6 Footwear should be clean, appropriate for clothing, protective and fit securely.

a. Shoes should be non-permeable entirely white or black.
b. Shoes must have a closed toe and closed heel.

c. Canvas shoes or "crocs" with holes are not permitted in patient care areas.
d. Shoes and shoelaces must be kept clean. Shoelaces must be white or match shoes.
e. Staff must wear hosiery or socks at all times.

25.7 Cloth stethoscope covers or decorative items attached to stethoscope are **not permitted**.

25.8 Uniform/Clothing Standards:
a. Undergarments must be worn and inconspicuous under uniform or clothing.
b. Clothing must be clean and neatly pressed.
c. Faded / yellowish, discolored or ripped clothing is not acceptable.
d. All clothing should be non-see through.

Sub- policy (INT- I.3): Professional Relationships:

Physicians must demonstrate professional behavior in their interactions with each other, as well as with students, patients, other trainees, colleagues from other health professions, and support staff. Any behavior (inappropriate words or actions) that interferes with quality of healthcare environment is considered an "unprofessional behavior".

Sub- policy (INT- I.4): Reporting Responsibilities

Physicians involved in the intern training shall report to the departmental medical students committee, chairman of the department and the Vice dean of clinical affairs (VDCA).

It is the responsibility of the MRP and or supervisor to promptly report if a medical student exhibits any of the following:

a) Attitudes suggesting disrespect, abuse or exploitation of a patient.
b) Failure to interact with patients professionally and ethically.
c) Unprofessional and or unethical attitudes towards supervisors or colleagues.
d) Engagement in inappropriate behavior at the hospital premises.
e) Obstacles to the acquisition of medical and clinical experience.

The chairman of the Medical students committee of the concerned department is responsible for addressing any of the reported concerns and shall report to the chairman of the department. The chairman of the department shall ensure that proper action is taken and that the VDCA is informed of the concerns and the corrective actions if any. The VDCA reports directly to the Dean of the FOM who chairs both the Faculty and Medical boards.

Sub- policy (INT- I.5): Interns roles in the field experience environment

- Attend and assist the consultant, senior registrar, registrar and resident on rounds in the unit, operating rooms, labor and delivery rooms and clinics.
- Daily round on patients to be repeated in the afternoon if instructed by a senior team member.
- Attend daily teaching rounds with their respective teams.
- Participate in the scientific activities of the department.
- Complete history and physical examination, and order investigations after consultation with the resident or other senior staff as soon as the patient is admitted to the unit.
- Fill all request forms legibly and complete the relevant information required for the investigation requested and enter it in the computer.
- Clerk new admissions within one hour for routine cases, and immediately for emergency cases.
- Follow recommendations of the other departments in preparing patients for specific procedures.
- Follow-up on the results and reports of the patients and make sure that they are completed and conveyed to a senior member of the team.
- Write the progress notes of their respective patients as instructed by the resident daily. All documentations will be mandatory at KAUH under the part (intern notes) in the hospital information system (Phoenix). These include the full clinical data for any requested investigation or procedures. For all affiliated hospitals, documentations will depend on their policy regarding that issue.
- Attend and inform the resident in the team or on-duty of routine and emergency admissions.
- Inform the resident immediately of any serious and life-threatening situations arising in the patients present in the unit.
- The House Officer is obliged to respond immediately when called or paged to see a patient or a patient's result, and not to initiate any management without the presence or approval of a senior member of the team, unless immediate intervention by the house officer is life saving.
- Will not perform any surgical or invasive procedure in the clinic, unit or operating room unless supervised by the consultant, senior registrar, registrar or resident.

- Make sure that follow-up appointments for the patient are arranged before discharge from the hospital.
- When the on-call is over, NOT to leave the hospital without conducting a proper endorsement of the on-call activities to the house officer of the incoming on call team.
- When assigned to the Day Care Unit, should remain in the unit from 08:00 to 17:00.
- The house officer's notes or documentations are not considered official unless they bear his/her signature and stamp and are countersigned by the resident.
- Should seek the counter signature of the resident on all notes written and documents filled by him/her.
- Extraction of blood and insertion of intravenous routes for patients of your team, and for all patients in the unit during on call hours. A phlebotomist and the unit nurses, if available, will provide assistance.
- Not to prescribe Narcotics or controlled drugs without consulting a senior member of the team, and when doing so, immediately sign and stamp the medication sheet only for the patients for whom the drug was prescribed.
- Staying in the hospital beyond duty hours is not allowed unless justified.
- The house officer is obliged to respect and abide by KAUH's regulations concerning clothing and the general appearance.
- The house officer is obliged to wear the white coat and identification card throughout his/her stays in the hospital premises.
- The house officer is obliged to immediately, commence all procedures leading to his/her acquisition of a personal pager, stamp, and identification card.

Sub- policy (INT- I.6): Confidentiality Agreement

1. Confidential Information will also include any information that has been disclosed by a third party to the Provider and governed by a non-disclosure agreement (NDA).
2. The confidential information will remain exclusively the property of KAUH. The intern cannot use confidential information for any purpose that cause harm to KAUH.
3. The INTERN may disclose any of the Confidential Information:
   a. to such of his colleagues, representatives and advisors that have a need to know for the Permitted Purposes
   b. to a third party where the Provider has consented in writing to such disclosure; and
   c. By the request or requirement of any judicial, legislative, administrative or other governmental body.

The Intern agrees to retain all Confidential Information at his usual place of work. Further, the will not be used, reproduced, transformed, or stored on a computer or device that is accessible to persons to whom disclosure made be made, as set out in this agreement.

4. Upon the expiration or termination of this Agreement, the Intern:

   a. returns all Confidential Information to KAUH and will not retain any copies of this information;
   b. destroys or have destroyed all memoranda, notes, reports and other works based on or derived from the INTERN's review of the confidential information; and
   c. provides a certificate to KAUH that such materials have been destroyed or returned, as the case may be.

5. If the INTERN loses or fails to maintain the confidentiality of any of the Confidential Information in breach of this Agreement, the INTERN will immediately notify KAUH and take all reasonable steps necessary to retrieve the lost or improperly disclosed Confidential Information.

Sub- policy (INT- I.7): Vacations

Vacations for 1-year internship training are as follows:

- 15 days Annual vacation
- 5 days Eid vacation in 1 Eid holiday

Note: Academic leaves are NOT allowed.

Guidelines for Eid vacation:

1. Interns will follow the hospital rules regarding the duration of the vacation.
2. During the vacation, you will have normal working days which include on-call duties.
3. For the hospitals that follow the government duration of vacation, the period will be divided to 2-3 parts to allow maximum number of interns to take their Eid vacation.
4. Other hospitals that have shorter period of Eid vacation, there will be only one part which include the day of the Eid and 4 days after. Minor adjustments can be done if these didn't interfere with the hospital policy.
5. The general rules in applying for Eid vacation are first come, first served and maximum of 50% of interns can take the vacation at any point.
6. If all interns of one department at KAUH agreed to take their Eid vacation in different arrangement than the designed parts, that will accepted as long it maintains the 50% rules.

For example, if there was 2 periods: 1-5 and 6-10 but ALL interns of a rotation agreed to take 3-7 in which 20 interns out of 40 interns will take their Eid vacation that will be acceptable.
Interns are not allowed to stop their rotation in order to study for the exam, attending exam or participating in any activity or training that is not part of their internship.

Guidelines for Annual vacation:

1. Interns are allowed to have maximum of fifteen (15) days of annual leave and additional five (5) days that can only be taken during one of the Eid vacations.
2. All vacation request must be submitted to the internship office teo (2) weeks before the rotation at KAUH or at least 1 month before the rotation in any other affiliated hospital.
3. In case of special circumstances that required to submit the request late, special requests must be sent to internship office explaining the situation with all necessary documentation.
4. It is allowed to take only five (5) days in each request per rotation. No division or summation of the vacations within any rotation will be allowed in any circumstances. Any additional days will follow the policy of absences.
5. All requests must be submitted to the internship office within the expected period and the final approval should be taken by the department.
6. The intern is fully responsible for retaining the approved request to the internship office. Failure of the submission will be subjected to disciplinary action which includes repeating part or whole rotation.
7. This policy doesn't include any emergency leave, for that; kindly refer to the absence policy.
8. In KAUH, not more than 25 % of interns are allowed to take annual leaves at any point of time for major rotations excluding elective. For EId vacation, the maximum number of interns to take eid vacation is 50%. Kindly refer to the eid vacation policy.

Non-KAU Applicants

A. Graduated in Saudi Colleges within the Kingdom

1. Each intern is allowed to have 2 months rotation in KAUH in any specialty according to the availability.
2. Application should be at least 1 month before the rotation.
3. All requirement(s) must be ready which includes: request letter from your college, BLS certificate & medical clearance results (Blood Group, HBs Ag, HBs Ab, HCV Ab, HIV, Rubela

Ab IgG, Measles Ab IgG, Mumps Ab IgG, Varicella Zoster Virus Ab IgG, vaccines for Rubella, Measles, Mumps & Varicella-Zoster if negative) and PPD or Manoutx test (mandatory requirements)).

4. All rules and regulations of our KAU internship will be applied to you including our vacation policy.
5. Evaluation will not be sent / given unless clearance from the hospital was made.

B. Graduated from outside the Kingdom

1. The usual starting period for internship is on 1st of March and receiving applications will be stopped by middle of December.
2. No application will be received without the original Ministry of Education (MOE) letter.
3. All candidates will have to enter a written exam and interview. Written exam is composed of 30 MCQ items in general medical subjects with 1 essay. The interview will be held most of the time on the day of the written exam. Applicant(s) must submit all mandatory documents without any exception at least 1 month before the exam date which usually held on January each year.
4. Requirements for entering the exam are as follows:
    a. Original MOE letter (copies are not sufficient)
    b. Medical Clearance
        a. Lab works (Blood Group, HBs Ag, HBs Ab, HCV Ab, HIV, Rubela Ab IgG, Measles Ab IgG, Mumps Ab IgG, Varicella Zoster Virus Ab IgG) and PPD or Mantoux test.
        b. Vaccines (Diptheria, Hepatitis B and Meningitis) (Rubela, Measles, Mumps and Varicella Zoster)
    c. Passport copy
    d. National ID / Iqama copy
    e. Transcript of Records copy
    f. Graduation Certificate copy
    g. BLS Certificate copy
    h. 2 pcs. Personal photo
5. Attending Orientation Course is a mandatory.
6. The schedule and distribution will be only at the available positions and no changes of these are allowed. Only 2 months are allowed to be taken outside Jeddah which includes the electives. (at least 80% of rotation must be at KAUH)
7. All rules & regulations of KAU graduates will be applied.

8. After finishing the clearance the intern will receive an internship certificate as long as he / she spent the whole year under our supervision. The name on the certificate will be based on the name in the passport regardless of what is written in the graduation certificate.
9. Salary is available for Saudi's, son of Saudi mother and Gulf citizen however the faculty of medicine is responsible to send the paper work to the ministry. The Ministry in Riyadh has the full authority of providing the salary or not according to their regulation.
10. No freezing is allowed during internship training and the intern must finish all requirements within 1 Gregorian year from the start of rotation.
11. All applicants are not allowed to communicate directly with any affiliated hospital(s).
12. All communication will be held through our official e-mail service. Failure to respond to this e-mail indicates withdrawal from the program. Our official e-mail: med.vd.ca@kau.edu.sa

Sub- policy (INT- I.8): Completion of all 6-year requirements

1. Having clearance from the Vice Dean of Clinical Affairs along with Transcript of Records copy.
2. Attending the orientation course and passing the practical workshop are MUST to start the internship year.
3. Recent medical clearance & active BLS certificate are must be available at least 2 months before the start of internship. Failure will stop the internship processing completely.
4. Medical clearance includes Blood Group, HBs Ag, HBs Ab, HCV Ab, HIV, Rubela Ab IgG, Measles Ab IgG, Mumps Ab IgG, Varicella Zoster Virus Ab IgG, vaccines for Rubella, Measles, Mumps & Varicella-Zoster if negative) and PPD or Manoutx test (mandatory requirements). In case of positive PPD test result or any vaccination, clearance must be presented from the Staff Health Clinic and following their guidelines in follow-up are mandatory. Failure of this will stop the training.
5. The name on your graduation certificate must match completely your name in the passport in any respect. The internship certificate will base on the graduation certificate name regardless of the passport name after getting the right consent from the intern about that issue.
6. Salary is available for Saudi's, son of Saudi mother and Gulf citizen however the faculty of medicine is responsible to send the paper work to the ministry which have the full authority of providing the salary or not according to their regulation. The paper works for salary includes filled data sheet, medical clearance, BLS, copy of passport and national ID, 6th year clearance, IBAN (from the bank) & orientation certificate. All of these requirements must be filled 2 months before the start of internship year and failure of this will stop the paper processing for salary.
7. Signing all necessary request forms

8. To ensure receiving the e-mail from internship office, the intern must add the e-mail address to the contact information within the e-mail service.
9. Collecting required documents:
   All documents must be collected by the sub-group leaders & all documents from all 6th year student of each group must be given altogether. Failure of this will be reported to the Vice Dean to take a necessary action. The deadline for collecting the paper will be provided by February and no extension will be allowed from this deadline.
10. Orientation Course:
    All part of the orientation course must be attended. Missing any part will be considered as failure of attending the orientation course as a whole. This is considered as withdrawal from the internship year.
    Orientation course is usually held within 5 days in which all interns must attend the theoretical part which last for half a day. The rest will be designated as workshop in which each intern will attend only a half-day in the Skills Lab. Scheduling for the practical sessions will be assigned by the interns themselves and final schedule will be sent by the main male & female leaders 2 weeks before the orientation. No changes are allowed after that. Orientation cannot be rescheduled and all interns must know the exact days of the course before making any plan.

Sub- policy (INT- I.9): Issuing Internship Certificate

Requirements:

1. Completion of 12 months training under KAU complete supervision
2. Clearance from the hospital.
3. Submitting copy of graduation certificate and passport (this must be submitted at least 2 months before finishing or the internship certificate will be delayed).
4. Receiving all evaluations with no repetition or punishment.
5. In special circumstances, that requires the intern receives his internship certificate before finishing all requirements which includes:
   1. Document the necessity of having the internship earlier. This document should include a deadline from the body that the intern is applying for.
   2. Consent about the true information's provided and also the commitment of the intern to fulfill all requirements within the expected period. Failure of that will hold all kinds of clarification until all requirements achieved.
   3. Intern must have good conduct and not in academic punishment of any kind.

4. Preliminary evaluation of only pass mark will be initiated and will be permanent in the intern's record if the final evaluation grade was not received within the expected time.

Sub- policy (INT- I.10): Change of Schedule

1. There is no changes in the schedule after submitting the final schedule in the internship office (whether electronically or paper).
2. Special circumstances of changing part of the schedule.
   A. Interns are allowed to make changes within KAU hospital if the request of changing was 2 weeks before the rotation and that there is availability in both rotations.
   B. Changing from KAU hospital to affiliated hospitals is allowed if that is applied 2 months before the rotation and there is availability in the requested hospitals as long as the intern maintained at least 1 major rotation within KAU hospital.
   C. No changes is allowed from any affiliated hospital after sending the requests whether accepted or requests still pending. If there was a strong documented & legitimate reason for such changes the document must be applied 2 months before the rotation. List of legitimate reasons are available in the FAQ's.
   D. Changing the rotation within the affiliated hospitals or switching the rotation between the interns and the periods are generally allowed under 2 conditions:
      1. Application should be applied 2 months before the rotation.
      2. Acceptance from the affiliated hospital of the interns request switching will not be processed until 2 signed requests are provided.
3. Interns are not allowed to officially communicate directly to affiliated hospitals and all changes will not be accepted if it was through the internship office.
4. The evaluations from any hospital will be accepted based on the internship office records. In case of changes made by the intern without proper requesting the changes from the internship office, the intern will be punished by repeating the whore rotation and subjected for other academic punishment.
5. If the intern planned to apply for abroad training he/she must schedule his/her rotation in the system as outside KSA or any rotation within KAU hospital. Once the intern accepted for any outside KSA rotation, he must immediately inform the internship office within 3 working days. Failure for that will be subjected the intern for academic punishment including repeating the rotation. The internship office will provide all academic support to help the intern getting his abroad training as long as he/she is following the policy & procedures of the internship.

Purpose:

This policy outlines the professional responsibilities related to the following aspects of Internship Training Program:

1. Identification of Most Responsible Physician (MRP)
2. Definition of Intern
3. Rotation Guidelines
4. Professional Relationships
5. Reporting Responsibilities
6. Medical students roles in the undergraduate medical environment
7. Confidentiality Agreement

1. Consolidate, expand and apply knowledge of the etiology, pathology, clinical features, natural history and prognosis of common and important presentations at all stages of life
2. Demonstrate safety skills including effective clinical handover, graded assertiveness, infection control, and adverse event reporting.
3. Communicate clearly, sensitively and effectively with patients, their family, doctors and other health professionals.
4. Perform and document a patient assessment, incorporating a problem-focused medical history with a relevant physical examination, and generate a valid differential diagnosis.
5. Safely perform a range of common procedural skills required for work as general physician.
6. Recognize and assess deteriorating and critically unwell patients who require immediate care. Perform basic emergency and life support procedures
7. Demonstrate ability to screen patients for common diseases and provide care for common chronic conditions.
8. Respect the roles and expertise of other healthcare professionals, learn and work effectively as a member or leader of an inter-professional team, and make appropriate referrals.

Scope:

This policy applies to all physicians who participate in the teaching and supervision of intern at the Faculty of Medicine (FOM) at King Abdulaziz University (KAU) while performing their clinical rotations at King Abdulaziz University Hospital (KAUH).

Definitions:

For the purpose of this policy the following definitions are used:

1. **Interns** are 7th year medical students are holder of MBBS degree but still lacking the field experience. They are not still licensed by the Saudi Commission for Healthcare Specialties (SCFHS).
2. **Most responsible physician** ("MRP") is the physician who has final accountability for the medical care of the patient, whether or not a student is involved in the clinical encounter.
3. **Supervisors** are physicians who are assigned by the KAUH & affiliated hospital to assume the responsibility to guide, observe, and assess the educational activities of medical students. The supervisor of a medical student involved in the care of the patient may or may not be the most responsible physician for that patient. Residents and fellows often serve in the role of supervisors but do not act as the most responsible physician for patient care.

Community Services

COM-I

Document ID: COM-I.1	Title: Community Engagement Plan		
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Approved By: Faculty Board University council	Date Approved: 07/ 11/ 2016 27/ 11/ 2016		
Effective Date:			
Revision No.: --------	Reviewed By: --------	Date Reviewed: --------	Date Next Revision: --------

Policy (COM-I.1.1):

The institution must have a documented ratified annual plan for community services and environmental development with timely defined programs.

Policy (COM-I.1.2):

The plan must be based on community needs assessment.

Policy (COM-I.1.3):

The plan must be based on the capacity of the institution to respond to the community needs.

Policy (COM-I.1.4):

The plan implementation must be consistently monitored and evaluated.

Purpose:

1.21 The plan draws the roadmap for fulfilling the diverse community needs: services, education, and development.

1.22 The ratification of the plan by the Faculty Council secures funds and commitment to implementation.

1.23 The plan guarantees accountability of implementation.

1.24 Assessment of community needs and the capacity of the institution to respond to the needs ensure success of the plan and sustainability of the implementation.

1.25 Success of the plan builds and sustains trust, credibility and reputation of the institution by the community it is entrusted to serve.

Scope:

- Vice Deanship for Development (VDD)
- Community Services Unit (CSU)
- Quality & Academic Accreditation Unit (QAAU)
- Strategic Planning Unit (SPU)

Responsibilities:

- **VDD:** ensures approval of needs assessment based plan

- **CSU**:

- defines the bodies which collaborate with the community partners for community services and activities
- designs Community Services Guide, brochures, booklets showing various bodies and their contacts and markets their services
- conducts the needs assessment, puts and implements the plan

- **SPU**:

- monitors the implementation of the plan
- ensures the plan aligns with the programs and projects of the institutional strategic plan

- **QAAU:**

- reviews compliance and adherence to the policy
- evaluates the results

Procedure:

No.	Responsible Person(s)	Procedure	Rationale
1	CSU	***In first week of July:*** - Conducts a community needs assessment from all stakeholders - Analyzes the results - Puts the annual plan	To ensure success of the plan, it must be community oriented
2	SPU	Ensures matching of the plan to the institutional strategic objectives	To secure sustainability of the implementation
3	VDD	***In first week of October:*** - Obtains approval of the plan from the Faculty Council	To guarantee accountability
		In first week of November: - Sends the approved plan to CSU, QAAU, SPU, departments, scientific societies, centers of excellence, scientific chairs, and CME unit	
4	QAAU	Sends to the SCU: - data collection forms - Required KPIs	
5	CSU	Ensures publicization of the approved plan through the: - Faculty website - Students guide - Faculty Guide - Community Services website, guidebook, brochures, booklets	To communicate the plan to relevant parties and ensure compliance to the provision of the required data.
6	Departments, Scientific Societies, Scientific Chairs, and Centers of	***Within two working weeks from receipt of the plan:*** - Define the community activities they can share with - List the faculty members who are	To document activities and help monitor progress in performance

	Excellence	going to share in these activities - Send those lists to the CSU	
		In the first week of May: Prepare a list of the number of faculty and students who shared in community services annually	
7	CSU	***In the fourth week of May:*** - gathers data from departments, scientific societies, centers of excellence, scientific chairs, and CME Unit - analyzes the collected data ***In first week of June:*** Sends an annual report on the implementation of the plan and the analyzed data to the QAAU	To determine the achievements and the challenges and help put an improvement action plan
8	QAAU	***In second week of June:*** Calculates the KPIs and the success indicators ***In first week of September:*** - reports compliance to the VDD - sends KPIs report to VDD, SPU and CSU	To secure quality assurance of the process and outcomes

Records:

1. Needs assessment results
2. The approved plan with the Faculty Council meeting minutes
3. Community Services Guide, brochures, booklets
4. Lists of participating faculty and students in community services and activities
5. CSU report
6. QAAU compliance and KPIs report

Document ID: COM-I.2	Title: Institution- Community Interaction		
Prepared By: QAAU	Date Prepared: 11/6/2015		
Approved By: Faculty Board University Council	Date Approved: 07/ 11/ 2016 27/ 11/ 2016		
Effective Date:			
Revision No.: --------	Reviewed By: --------	Date Reviewed: --------	Date Next Revision: --------

Policy (COM-I.2):

The institution invites the participation of community stakeholders in formal institutional councils and committees, and defines the framework of this participation.

Purpose:

Participation of stakeholders in formal institutional councils and committees secures effectiveness of the community services plan, effectiveness of the institution graduates and their fitness to the purpose required by the employability market. This also ensures fund raising and building and sustaining trust between the community and the institution.

Scope:

- Academic Leaders (Dean and Vice Deans)
- Director of KAUH
- Faculty Council

Responsibilities:

- **Academic Leaders and the Director of KAUH:**
  Define the community stakeholders and the framework for their participation in formal committees and councils.

- **The Faculty Council:**
  Approves and ratifies the selected list and the framework for the community stakeholders' participation

Procedure:

No.	Responsible Person(s)	Procedure	Rationale
1	Dean; Vice Deans; and Director of KAUH	***In second week of October:*** - Define the representatives from community stakeholders relevant to the approved plan - Define the framework of the stakeholders' participation in the formal councils and committees enlightened by the approved plan	
	Faculty Council	- Approves the list of the selected stakeholders and the recommended framework	
	VDD	***In the third week of October:*** - Sends a list of the defined stakeholders and approved framework to the CSU	
		Whenever appropriate according to the annual meetings calendar: - Invites the defined stakeholders to some meetings of the formal councils and committees which handle issues relevant to the relation between the institution and the community	***Issues relevant to the relation between the institution and the community defined as:*** All that contribute to the development and maintenance of healthy communities as: - Services - Education - Community-based research
	Stakeholders	***After each meeting:*** - Send their feedback to the Dean	

Records:

1. A copy of the approved list of defined stakeholders and the minutes of the Faculty Council in which this approval is taken.

2. A copy of the ratified framework for stakeholders' participation in the formal councils and committees with clear terms of references.

3. Minutes of meetings which enclose the defined stakeholders

Document ID: COM-I.3	Title: Quality Assurance of Community Engagement Activities		
Prepared By: QAAU	Date Prepared: 12/6/2015		
Approved By: Faculty Board University Council	Date Approved: 07/ 11/ 2016 27/ 11/ 2016		
Effective Date:			
Revision No.: --------	Reviewed By: --------	Date Reviewed: --------	Date Next Revision: --------

Policy (COM-I.3.1):

The institution has a central unit in which records for community services are kept as a central database.

Policy (COM-I.3.2):

All community services and activities are documented and kept in the central database.

Policy (COM-I.3.3):

Annual reports of community services and activities are issued and communicated to the stakeholders.

Policy (COM-I.3.4):

The institution must measure the community stakeholders' satisfaction of the services and activities it provides and of the level of its graduates. The results of evaluation must be analyzed and utilized in decision making and improvement of community services.

Purpose:

1. An updated database retained in a central unit would serve as a source for evaluation data, trend analysis to deduce progress or decline of performance in the sector of community engagement.
2. Regular evaluation and reporting of community services secures its continuous quality improvement.

Scope:

- Community Services Unit (CSU)
- Quality & Academic Accreditation Unit (QAAU)
- SPU
- Vice Deanship for Development VDD

Responsibilities:

- **VDD:**
- forms a CSU, with clear bylaws (structure and strategies) and ratified.

- **QAAU:**
- Defines the policies and procedures for community-institution relationship.
- Defines the data required for calculating and monitoring of the KPIs in the community services sector and the evidences required to prove fulfillment of the corresponding standard.

- **CSU:**
  - Puts a timed plan for collecting the required data
  - Analyzes the collected data
  - Prepares the required evidences
  - Issues an annual report

Procedure:

No.	Responsible Person(s)	Procedure	Rationale
1	CSU	***In first week of May:*** - Conducts an evaluation of the stakeholders' satisfaction of the community services and activities - Analyzes the results	Stakeholders include: patients, their families, lay people in the community, employers, etc.
		In the first week of June: - issues a report on evaluation results - sends the report to VDD and QAAU	The report shows the points of weakness and strengths as well the challenges and opportunities.
		In first week of July: - Conducts a community needs assessment from all stakeholders - Analyzes the results - Puts the annual plan	To ensure success of the plan, it must be community oriented
2	SPU	Ensures matching of the plan to the institutional strategic objectives	To secure sustainability of the implementation
3	VDD	***In first week of October:*** - Obtains approval of the plan from the Faculty Council	To guarantee accountability
		In first week of November: - Sends the approved plan to CSU, QAAU, SPU, departments, scientific societies, centers of excellence, scientific chairs, and CME unit	
4	QAAU	Sends to the SCU: - data collection forms - Required KPIs	
5	CSU	Ensures publicization of the approved plan through the: - Faculty website	To communicate the plan to relevant parties and ensure compliance to the provision of

		- Students guide - Faculty Guide - Community Services website, guidebook, brochures, booklets	the required data.
6	Departments, Scientific Societies, Scientific Chairs, and Centers of Excellence	***Within two working weeks from receipt of the plan:*** - Define the community activities they can share with - List the faculty members who are going to share in these activities - Send those lists to the CSU	To document activities and help monitor progress in performance
		In the first week of May: Prepare a list of the number of faculty and students who shared in community services annually	
7	CSU	***In the fourth week of May:*** - gathers data from departments, scientific societies, centers of excellence, scientific chairs, and CME Unit - analyzes the collected data ***In first week of June:*** Sends an annual report on the implementation of the plan and the analyzed data to the QAAU	To determine the achievements and the challenges and help put an improvement action plan
8	QAAU	***In second week of June:*** Calculates the KPIs and the success indicators ***In first week of September:*** - reports compliance to the VDD - sends KPIs report to VDD, SPU and CSU	To secure quality assurance of the process and outcomes

Records:

1. The memo for establishing the CSU
2. The document showing the nature and tasks of CSU
3. Annual report of CSU
4. Ratified annual plan for community engagement
5. Trend analysis report from the QAAU for KPIs related to community engagement
6. Report of stakeholders' satisfaction of community services

Document ID: COM-I.4	Title: Reinforcing Participation in Community Services		
Prepared By: QAAU	Date Prepared: 12/6/2015		
Approved By: Faculty Board University Council	Date Approved: 07/ 11/ 2016 27/ 11/ 2016		
Effective Date:			
Revision No.: --------	Reviewed By: --------	Date Reviewed: --------	Date Next Revision: --------

Policy (COM- I.4):

The institution must include participation in community services and activities as a criterion for faculty promotion and assessment.

1. Criteria which define faculty promotion and assessment should include extent and nature of participation in community services, education and targeted research:

- ***1.1 Annual number of community services***
- ***1.2 Annual number of community educational and professional programs provided by the faculty member***
- ***1.3 Annual number of research which responds to community needs***
- ***1.4 Annual number of funds provided by the community to conduct research, community services***
- ***1.5 The annual number of newly established scientific chairs, centers of excellence, service units, etc. funded by the community***

2. Those criteria must be ratified by the Faculty Council

3. Those criteria must be publicized to all stakeholders through various methods

Purpose:

Including participation in community engagement in promotion and assessment of faculty, secures serious contribution and accountability.

Scope:

- Vice Deanship for Development (VDD)
- Dean
- Committee for Development of Academic Curricula (CDAC)
- QAAU
- Faculty Council
- CSU

Responsibilities:

- Vice Deanship for Development:

- puts the criteria for promotion and assessment of faculty members based on quality references to ensure validation
- ensures that the criteria is implemented

- QAAU:

- defines the criteria for promotion and assessment of faculty members backed by standards
- designs the form for collection of data based on the defined approved criteria

- Dean & VDPGR:

- approves the inclusion of the criteria in the academic portfolio

- Faculty Council: ratifies the inclusion of the criteria in promotion and assessment

- CSU:

- collects data and analyzes it
- issues an annual report

Procedure:

No.	Responsible Person(s)	Procedure	Rationale
1	VDD	***In first week of September:*** Publicizes approved criteria and this policy to all stakeholders	
2	QAAU	***In first week of November:*** Sends data collection tools to the CSU	To be able to calculate relevant KPIs
3	CSU	***At the end of the first and second semesters:*** - Collects required data - Sends data to QAAU	
4	QAAU	***In the first week of June and within two working weeks:*** - Analyzes the collected data - Calculates KPIs	To interpret trend and determine progress, decline or plateau of performance in participation in community services
		In first week of July: Sends the calculated KPIs and its trend analysis to CSU and VDD	
5		***In first week of September:*** Sends an annual report to VDD and Dean	
	In case there are unsatisfactory results concerning a specific person:		
6	Dean & VDPGR	- meets formally with the concerned person - discusses the reasons - decides an objective judgment	

Records:

1. Faculty Council approval of the promotion criteria
2. CSU report
3. Report of dean and concerned person meeting in an incident (classified document)

Document ID: COM-I.5	Title: Reinforcing Students' Participation in Community Services		
Prepared By: QAAU	Date Prepared: 12/6/2015		
Approved By: Faculty Board University Council	Date Approved: 07/ 11/ 2016 27/ 11/ 2016		
Effective Date:			
Revision No.: --------	Reviewed By: --------	Date Reviewed: --------	Date Next Revision: --------

Policy (COM- 1.5):

Through the formal educational curriculum, students obtain and enhance knowledge, skills and attitudes necessary to contribute to the development and maintenance of healthy communities. They analyze, develop, carry out and evaluate methods of prevention, advocating and resolution of social and individual problems and obstacles.

Purpose:

To prepare students for:

- work with individuals, groups and communities in reducing community fatigue
- practice of human services in a variety of areas including advocacy and/or direct service delivery with groups and individuals
- Community- based scholarship (research and education).

Scope:

- Vice Deanship for Development (VDD)
- Dean
- Committee for Development of Academic Curricula (CDAC)
- QAAU
- Faculty Council

- CSU

Responsibilities:

- Vice Deanship for Development:

- Ensures the policy is communicated to the students and relevant parties

- CDAC:

- Embeds the foundations of community relationships in the formal curriculum knowledge, skills, attitudes, experience, application and practice

- QAAU:

- Revises and monitors the incorporation of foundations of community engagement in the educational program

- Dean:

- Approves the incorporated foundations through the CDAC

- Faculty Council:

- Approves the educational program
- Approves the policy

- CSU:

- Acts as a central database for community activities conducted by students (intra- and extra-curricular

Procedure:

No.	Responsible Person(s)	Procedure	Rationale
	CDAC	***In its first meeting in the academic year:*** - reviews the foundations annually based on the annual report issued by the QAAU - introduces modifications if required according to any updates in the required skills - Approves the modifications	
	VDD & QAAU	***In last week in June:*** - Revises the policy with vice deans - Recommends updates - Approves policy in Faculty Council	
	Faculty Council	- Approves the educational program - Approves the policy	
	VDD	Communicates the policy to course directors, heads of departments and CSU	
	CSU	- Formally registers all the community activities conducted through courses and update its database concerning this policy - Keeps copies of students' proposals and projects reports	
	Students	Should explicitly discuss these foundations in their assignments and projects	
	QAAU	**-** Monitors how these foundations are incorporated and implemented throughout the curriculum ***- By the end of each involved course:*** it evaluates the application of those foundations	The impact of those foundations on productivity of community activities by students is determined by reports issued from the relevant courses (community medicine; professionalism; patient safety)

		using defined performance indicators related to the course/ program learning outcomes ***- In the annual program report by the beginning of the new academic year in October:*** it analyzes the impact of those foundations on productivity of community activities by students	

Records:

1. Ratified policy and modified program/ courses
2. CSU database and exemplary documents
3. QAAU annual report
4. CDAC minutes

Students' Research

SR-I

Document ID: SR-I	Title: Students' Research as a Graduation Requirement		
Prepared By: SRAU	Date Prepared: 12/6/2015		
Approved By: Faculty Board University Council	Date Approved: 07/ 11/ 2016 27/ 11/ 2016		
Effective Date:			
Revision No.: --------	Reviewed By: --------	Date Reviewed: --------	Date Next Revision: --------

Policy (SR- I):

Through the formal educational curriculum, students must perform at least one complete research before graduation as a graduation requirement. The research must be either published, or accepted for publishing or presented in a conference or scientific forum.

Purpose:

To enable graduates to:

1. Acquire the competency "Researcher & Scholar" as set by national and international medical graduates competences and employability skills required in the health professions employability market
2. Be research literate
3. Have an high probability of being accepted in national and international residency training programs

Scope:

- Vice Deanship for Postgraduate Studies & Research (VDPGR)
- Students' Research Curriculum Committee (SRCC)
- QAAU
- Students' Research Assessment Unit (SRAU)
- Committee for Development of Academic Curricula (CDAC)

- Faculty Council

Responsibilities:

- Vice Deanship for Postgraduate Studies & Research:

- Ensures the policy is communicated to the students and relevant parties
- Supports the SRAU administratively
- Keeps statistics of the students' research and monitors it annually
- Ensures the policy is implemented

- Students' Research Curriculum Committee:

- Designs a research-led module which is evidence-based and runs longitudinally throughout the formal curriculum
- Specifies the objectives at each level
- Specifies the teaching/learning and assessment strategies

- QAAU:

- Revises the module to ensure matching with the required national and international competences and needs
- Monitors the implementation of the module in the educational program
- Evaluates the module at each stage of its implementation

- Students' Research Assessment Unit:

- Put the guidelines for students' research
- Assesses undergraduate students' researches
- Provides fast track for obtaining research ethics approval from Research Ethics Committee

- CDAC:

- Approves embedding the module in the formal curriculum
- Takes decisions that facilitate implementation of the module
- Approves the policies & procedures (guidelines) that govern the module

- Faculty Council:

- Approves the policy & guidelines

Procedure:

No.	Responsible Person(s)	Procedure	Rationale
	SRCC	- Designs a research-led module - Specifies the objectives at each level - Specifies the teaching/learning and assessment strategies	To put a curriculum for the research-led module which is evidence-based and that is compatible with the national & international competences & employability market
	QAAU	- Revises the module to ensure matching with the required national and international competences and needs - Monitors the implementation of the module in the educational program - Evaluates the module at each stage of its implementation by direct & indirect measures	To ensure the quality of implementation of the module & hence measures the actual achievement of the learning outcomes of the module
	CDAC	***In its first meeting in the academic year:*** Approves the module & its embedding in the formal curriculum	To secure formal production of students' research as a graduation requirement
	SRAU	Put the guidelines for students' research	To follow the best practices in conducting research, hence ensure productivity of high quality
	CDAC	Approves the guidelines	To secure the formal use of the guidelines
	VDPGR	Ensures the policy is implemented	To secure sustainability of the module
	Faculty Council	Approves the policy	

Records:

1. Students' Research Guidelines Manual
2. Outline of the module

Faculty's Research

FR-I

Document ID: FR-I	Title: Faculty's Research in Updating Curricula		
Prepared By: QAAU	Date Prepared: 12/6/2015		
Approved By: Faculty Board University Council	Date Approved: 07/ 11/ 2016 27/ 11/ 2016		
Effective Date:			
Revision No.: --------	Reviewed By: --------	Date Reviewed: --------	Date Next Revision: --------

Policy (FR- I):

Research and scholarly activities of teaching staff that are relevant to courses they teach are reflected in their teaching together with other significant research developments in the field.

Purpose:

- To update curricula that they teach
- To emphasize the value of research
- To utilize research results in teaching and learning

Scope:

- Faculty member
- Course Director
- Committee for Development of Academic Curricula (CDAC)
- QAAU
- Faculty Board

Responsibilities:

- Faculty member:

- Present the research results required to be introduced into the curriculum to the course committee
- Provide evidence that the research is relevant to the course
- Provide evidence that the research is published in a refereed ISI journal of high reputation

- Course Director:

- Discusses the initiative in the course committee
- Presents the initiative in the department council for decision-making
- Raises the initiative and minutes of the department meeting to the CDAC

- CDAC:

- Approves embedding the results in the curriculum

- QAAU:

- Revises the results as regards to their relevance to the module to ensure matching with the required national and international competences and needs
- Monitors the implementation of the module after introducing the results
- Evaluates the module at each stage of its implementation

- Faculty Board:

- Approves the changes

Procedure:

No.	Responsible Person(s)	Procedure	Rationale
	Faculty member	- Embeds research results into the course - Updates learning outcomes & content - Specifies the teaching/learning and assessment strategies after modifications	To align the learning outcomes after modification to PLOs, national & international competences
	Course Director	- Discusses the initiative in the course committee - Presents the initiative in the department council for decision-making - Raises the initiative and minutes of the department meeting to the CDAC	To include faculty members in the department in decision-making, hence ensure its implementation
	VDPGR	- Confirms that the research is published in a refereed ISI journal of good reputation - Send a formal letter to the course director and the coordinator of the CDAC of such confirmation	
	CDAC	- Approves embedding the results in the curriculum	To secure formal approval of the modifications
	QAAU	- Revises the results as regards to their relevance to the module to ensure matching with the required national and international competences and needs - Monitors the implementation of the module after introducing the results - Evaluates the module at each stage of its implementation	To ensure the quality of implementation of the module & hence measures the actual achievement of the learning outcomes of the module
	Faculty Council	Approves the changes	

Document ID: POL-I	Title: Formulation and Compliance to Policies & Procedures		
Prepared By: QAAU	Date Prepared: 12/6/2015		
Approved By: Faculty Board University Council	Date Approved: 07/ 11/ 2016 27/ 11/ 2016		
Effective Date:			
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Sub-policy (POL- I.1):

The Faculty of Medicine formulates, reviews and ratifies its policies and procedures provided that similar policies are not present in the policies and procedures of King Abdulaziz University; and which must align with the policies and procedures of the university and Ministry of Education.

Sub-policy (POL- I.2):

All departments, units, administrative offices and sectors in the Faculty of Medicine must comply to the policies and procedures of the Faculty of Medicine, King Abdulaziz University and King Abdulaziz University Hospital; and are not permitted to set or use any other regulations.

Sub-policy (POL- I.3):

Policies and procedures that are set by the Faculty of Medicine must be ratified by its governing council (Faculty Board).

Sub-policy (POL- I.4):

Policies and procedures that are approved by the governing council (Faculty Board) in the Faculty of Medicine must be reviewed regularly every five years to adapt to any environmental changes.

Purpose: To define the processes and procedures necessary for:

1. formulating and abiding to the policies and procedures that are set by the Faculty of Medicine and ratified by the Faculty Board
2. Regular reviewing and re-ratification of policies and procedures by the Faculty Board.

Scope:

- Vice Deanship for Development (VDD)
- Quality & Academic Accreditation Unit (QAAU)
- Faculty Board

Responsibilities:

- Vice Deanship for Development:

- Puts the policies and procedures with the QAAU and other Vice deans
- Ensures the policy is communicated to the relevant parties through formal curriculum committees

- QAAU:

- Sets the policies with the VDD guided by the standards and KAU policies and regulations
- Monitors compliance to the ratified policies and procedures

- Faculty Council:

- Approves the policy & procedure

Procedure:

No.	Responsible Person(s)	Procedure	Rationale
	VDD QAAU	- Put policies and procedures - Align policies to those of King Abdulaziz University and Ministry of Education - Align policies to the standards	Set the guidelines that govern performance in the Faculty of Medicine
	VDD QAAU	- Present the set policies and procedures to Phase- 1 & 2 Curriculum Committees	To engage stakeholders in putting the policies to ensure their compliance to them later.
	VDD	Raises the policies and procedures to the Faculty Board	To ratify the policies and procedures
	Faculty Board	Ratifies the policies and procedures	To impart formality to the policies and procedures for implementation, compliance and accountability

Section-2: King Abdulaziz University Hospital Policies and Procedures

King Abdulaziz University Hospital (KAUH) is a crucial learning resource to undergraduate and postgraduate students. It has its own policies and procedures that govern healthcare and academic practice in KAUH in an environment which is safe and professional.

KAUH policies and procedures can be accessed through the following link:

http://hospital.kaauh.org/departments/home/global/PoliciesAndProcedures/Forms/Allltems.aspx

Section-3: King Abdulaziz University Policies and Procedures

All KAU's policies and procedures that concern the Faculty of Medicine in educational, research, postgraduate studies or community services are copied and is currently being edited in a form which is compatible with this manual. In addition, each policy is tailed with its link to KAU website.

Faculty of Medicine Mission

The Faculty of Medicine at King Abdulaziz University is committed to provide high-quality educational programs; nurture scientific research; and community engagement in the Kingdom of Saudi Arabia.

Quality & Academic Accreditation Unit

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