KINGDOM OF SAUDI ARABIA
Ministry of Education
University of Tabuk
Faculty of Medicine

المملكة العربية السعودية
وزارة التعليم
جامعة تبوك
كلية الطب

MBBS Program

Quality Manual

2021-1443

Vice-Deanship for Quality & Development

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Endorsed by: Vice Deanship for Development & Quality Executive Committee – Dr. Amirah Alatawi–Vice Dean for Quality & Development Meeting # 2 – Date: 17/10/2020

Approved by: Faculty of Medicine Council – Meeting # 3 – Date: 26/10/2020

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Updated and reviewed by: Dr. Amirah Alatawi – Vice Dean for Quality & Development. Date 17/6/2021

Contents

INTRODUCTION

The Faculty of Medicine (FMd) in University of Tabuk (UT) is committed to continuous quality improvement on all fronts. Since its establishment, FMd has been adopting UT established practices regarding total quality management (TQM).

The purpose of this quality manual is to:

- Serve as a summarized source of information for the MBBS program quality assurance.
- Highlight the important quality management policies, guidelines and procedures which support the MBBS program in its goals.
- Ensure the quality of practices in all domains, the achievement of the program mission and goals and for program accreditation.

Since FMd derives all its guidance including policies and procedures, quality practices and systems from the university, this manual has been drafted using the university's manual as a guide.


VISION 2030
معتمد
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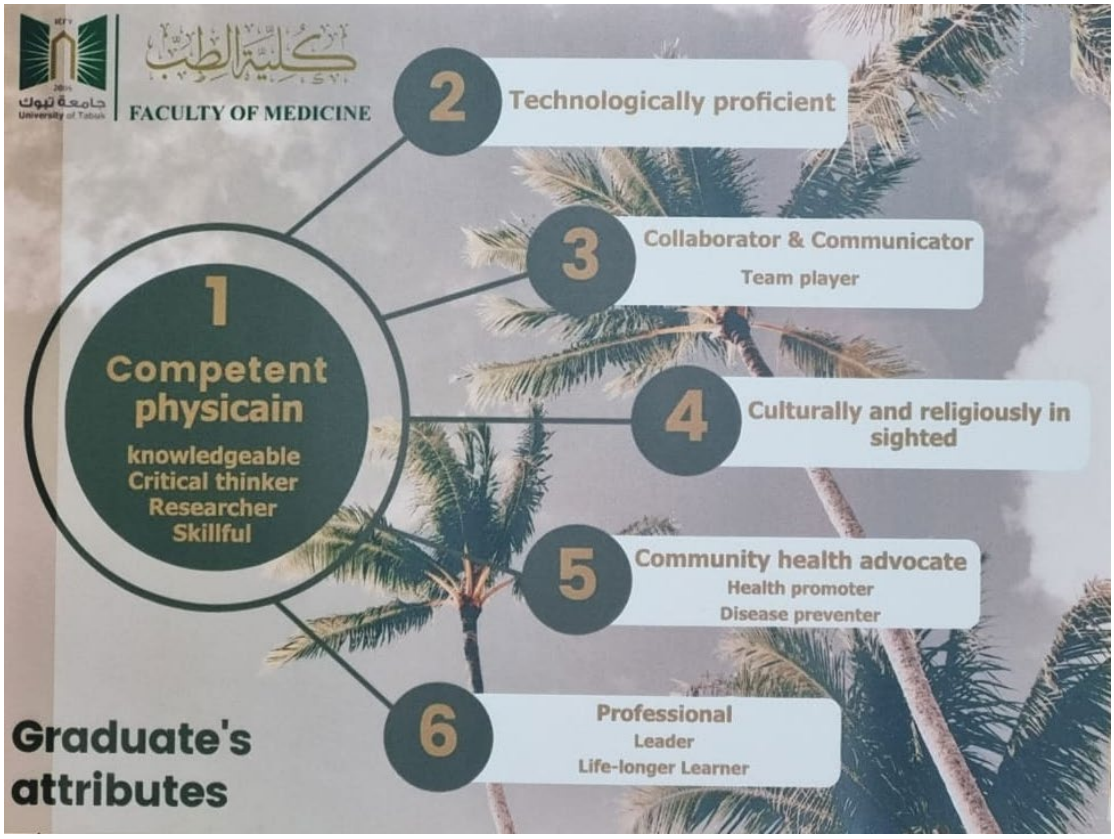
University of Tabuk
كلية الطب
FACULTY OF MEDICINE
MBBS Program Mission
Providing a supportive educational environment to graduate competent physicians able to conduct scientific research, serve the community and promote health.
MBBS Program Goals
1. To graduate distinguished competent medical physicians.
2. To equip the graduates with the skills needed to conduct scientific research.
3. To contribute in promoting community health and participate effectively in sustainable community partnership.
4. To develop a supportive educational environment that meets the needs of beneficiaries

MBBS Program Graduate Attributes



Definitions in Quality

Quality: It is satisfying the requirements of the customer who invested in the product or service and it is about being fit for the purpose for which the product or service was purchased.

Academic quality: Academic quality is a way of describing how well the learning opportunities available to students help them to achieve their awards. It is also about making sure that appropriate and effective teaching, support, assessment and learning opportunities are provided for them.

Academic standards: Academic standards are a way of describing the level of achievement that a student has to reach to gain an academic award (for example, a degree). It should be at a similar level across the Kingdom.

Quality assurance (QA): Quality assurance refers to a range of review procedures designed to safeguard academic standards and promote learning opportunities for students of acceptable quality.

Quality system: A quality system, also known as a Quality Assurance (QA) system or a Quality Management System (QMS), is a management system that helps to ensure the consistency of quality of the goods or services (education) that are supplied. Compliance with Quality System Standards is demonstrated by completion of a successful quality system audit conducted by a certified organization recognized by the Government which is in our case: The National Commission for Academic Accreditation & Evaluation (NCAAA).

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

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.

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.

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: These are the critical output documents of any procedure

The National Commission for Academic Accreditation & Evaluation (NCAAA)

The National Commission for Academic Accreditation & Evaluation has been established by the Higher Council of Education in Saudi Arabia with responsibility to establish standards and accredit institutions and programs in post-secondary education.

The system for quality assurance and accreditation is designed to support continuing quality improvement and to publicly recognize programs and institutions that meet required quality standards. The objective is to ensure quality across six predefined standards in all post-secondary institutions and in all programs offered in Saudi Arabia.

The Six Standards of NCAAA work to ensure that quality guides all policies, procedures and practices in the following:

1. Mission and goals
2. Program management and quality assurance
3. Teaching and learning
4. Students
5. Faculty members
6. Learning resources, facilities, and equipment

The program has adopted the six quality standards as well as the National Qualification Framework (NQF) standards to ensure effective quality practices at all levels and in all domains. These quality standards and processes are also in place to ensure that the mission, goals and program learning outcomes are derived from and consistent with that of the University, faculty, NQF and SAUDIMED.

The Vice Deanship for Quality and Development works in a systematic way to ensure compliance with best practices and quality standards as stated in the NCAAA Standards for Program Accreditation.

Faculty of Medicine Organization Structure

The organizational structure of FMd is built in accordance with its vision, mission and goals and based on the efficiency of the human and financial resources in the faculty.

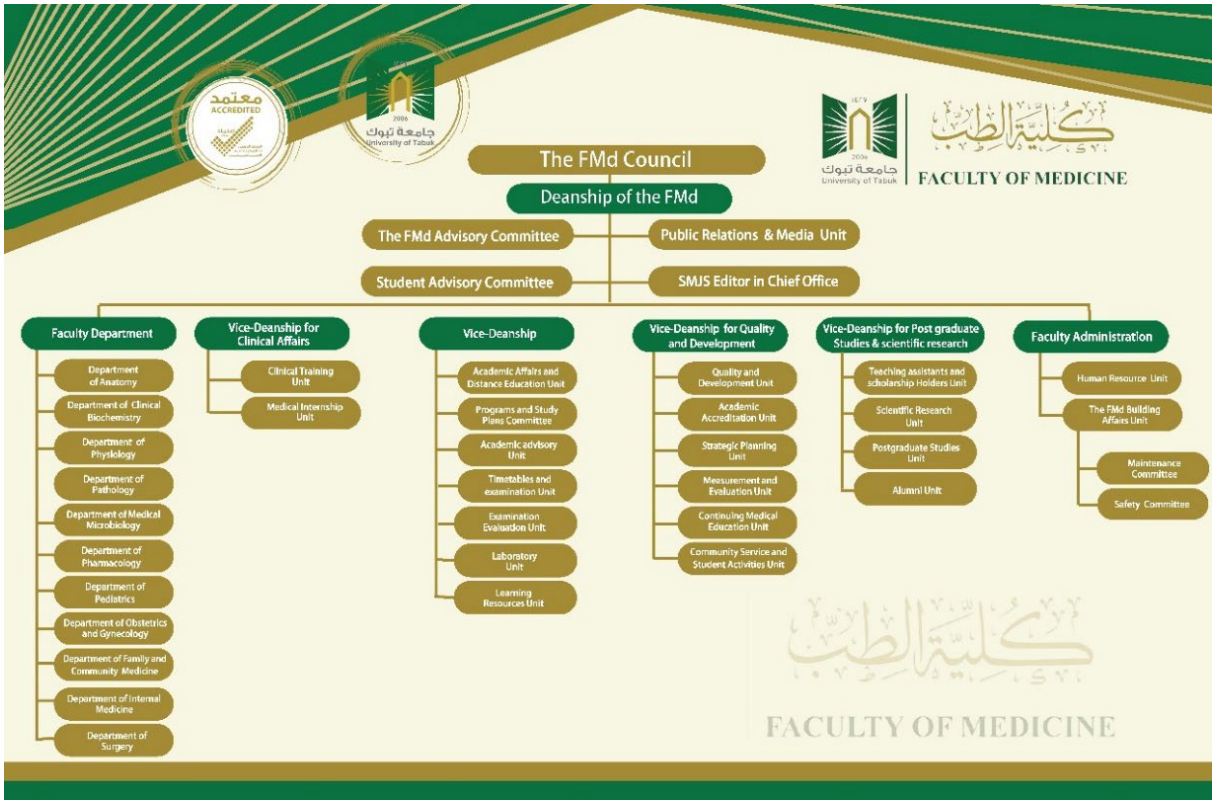
Mission of FMd is "Preparing physicians highly qualified in their field by integrating education and scientific research within a suitable education and administrative environment to play an effective role in healthcare service"

For building the organizational structure, the faculty went through several stages, starting with defining the faculty's objectives and preparing detailed lists of activities by deanship, vice deanships, academic departments and units; and then defining the organizational relationships connecting them together at different levels vertically and horizontally, then defining the communication network that allows the exchange of information, then drawing the organizational structure, and then preparing job description in a guide that explains the competence, tasks and functional relationships, and finally monitoring the organization process on a continuous basis.

Accordingly, the below FMd organizational structure (Figure 1) shows the deanship, academic departments, vice deanships, units, and committees and the relationship between them and lines of authority and the responsibility that links the parts of the faculty and the dimensions of the scope of supervision.

Their job description, authorities, and affiliation are described in details in the ***Guide for tasks and duties of Deanship, vice deanships, affiliated units and committees in FMd.***

Figure (1): Faculty of Medicine Organization Structure



Concept of Quality Planning and Review Cycle

The process of quality improvement involves assessing current levels of performance and the environment in which the programs are operating, identifying strategic priorities for improvement and setting objectives, developing plans, implementing those plans, monitoring what happens and making adjustments if necessary, and finally, assessing the results achieved. These steps involve a repeating cycle of planning and review. Major plans may involve a sequence of activities over a number of years, with a number of steps to be taken and the results of each step assessed at stages within that long term plan. While the monitoring should be continuous, there are normally two time periods when more formal assessments take place; one is annual with monitored performance and adjustments made as required, and the other is on a longer cycle in which major reviews are undertaken. Issues related to quality assurance and accreditation assessments should be planned to coincide with the seven-yearly external reviews for accreditation and re-accreditation conducted by the NCAAA.

Program Planning

UT published the first version of the procedural guide for programs and study plans in the academic year 2014/2015. The second updated version was published in 2019/2020 and the third updated version was released in 2021. The guide contains all procedures for the programs' establishment, accreditation, forms, and all other procedures. All programs in UT should be committed to UT policies, standards, and procedures that are published in the manual. (UT Procedural guide for Programs and study plans)

The MBBS program is committed to the institutional policies, standards, and procedures in the design, development and modification of the curriculum.

Introduction of a new program in UT starts with assessing the needs for this program, followed by preparing a program specification document that specifies the main

program objectives, learning outcomes, teaching strategies, and assessment methods in respect to the NQF.

All course specifications are then prepared according to the NCAAA standards and forms and updated accordingly. Appropriate learning outcomes for each course as well as teaching strategies and assessment methods and the distribution of the course topics are developed. Courses are prepared to achieve program goals and learning outcomes. The teaching and learning methodologies followed in each course are according to those stated in the course specification, which is considered as a contract between the instructor and the students. Before starting of the course/module and pre-module/course meeting or departmental council meeting is held to review and discuss all issues related to the course/module and the results of previous improvement plans, then plan for course delivery, check facilities and resources and distribute the tasks and responsibilities. Throughout the course/module; the course/module coordinator continuously monitors all course activities, ensuring the plan for delivery of the module is followed and facilitates difficulties and overcome obstacles faced during its delivery, gathering evidences for completion of course file and completing the course report. After the final assessment and release of exam results a post module/departmental meeting is to discuss the results, item analysis and CES analysis, get feedback from instructors, and finalizing the course report and course file. The coordinator submits the course file and the course report enclosing recommendations for improvement and an action plan. The course reports are prepared using NCAAA forms and provide an opportunity for the instructors to highlight issues they experienced or noted related to the effectiveness of the planned teaching strategies, and the extent to which the intended learning outcomes had been achieved. Students results in course reports can be updated after the release of the resit exam results.

The MBBS program regularly evaluates the feedback from beneficiaries to ensure that the program is achieving its mission and goals. Feedback is provided to all

faculty members, course coordinators and administration. The course and program reports are used annually to assess the quality of education and any obstacles facing the quality of this process.

Proposed changes are presented, discussed and approved according to the type and percentage of changes to the authorized level as stated in the UT procedural manual for programs and study plans. (UT matrix of authority for programs and study plan)

Intended Changes	Level of Approval →						
	Department Council	**Faculty Programs & Study Plans Committee**	**Faculty Council**	**UT Management of programs & study plans**	**UT Standing Committee of Programs and Study Plans**	**UT Council**	**Ministry of education**

The levels for approval changes in UT courses and programs are summarized in table (1). Any modification in the program plan must be documented and approved. The Faculty of Medicine strictly follows the university regulations in this concern.

Table (1): Levels for approval of changes in UT courses and programs.

Intended curriculum changes	Final Level of Approval
Program Level	
Changes including a program's mission, objectives, title, program length (total number of years/levels/ hours), program learning outcomes, program specification, study plan, and adding co-requisites or prerequisites	UT Standing committee of programs and study plans
Changes in ordering of PLOs, program KPIs, course code	UT Management of Programs and study plans
Change in the facilities, operational plan, dropping program co-requisites or pre-requisites	Faculty Council
Course Level	
Changes in the title, credit hours, length of period for teaching, timing in the program plan, update of course specification affecting >25% of CLOs, language of teaching	Standing committee of programs and study plans in UT
Course code	Management of Programs and study plans in UT.
Changes in course policies and regulations	Faculty council
Course teaching strategies, <25% change in CLOs, textbooks, reference materials, updates in medical knowledge in related topics, distribution of topics/weeks, methods for assessment; measurement and evaluation grading systems.	Department Council

Course planning, implementation, delivery and reporting

The Course/Module (C/M) team is the leader of successful implementation of Integrated curriculum. At faculty of medicine–Tabuk university, the C/M team is responsible for C/M management and is affiliated to Vice deanship of FMd. The C/M coordinator and the C/M team both are responsible for ensuring effective management of the C/M, its conduction according to what is stated in course specification and ensure using teaching, learning and assessment strategies and the methods designed in course specifications to achieve the course learning outcomes and the aligned program learning outcomes. The C/M team is also responsible for ensuring that delivery and management of the C/M follows Faculty and University educational policies and regulations. The C/M team is responsible for maintaining, updating all C/M data and information (C/M specification, timetable, exam blueprint, C/M report, …….) to assure high quality of this information with help of other parties for governing program planning, implementation and evaluation.

The role of Course/ Module (C/M) Team:

The role of the C/M team is to take responsibility for a particular C/M and to support the planning, delivery, monitoring, reviewing and development of C/M. It ensures that the C/M aligns with curriculum plan and, where necessary, coordinates with other C/M team and units, manages resources required for the C/M delivery and undertakes all monitoring, evaluation and reporting processes related to the C/M.

The responsibilities of C/M Team:

The C/M coordinator is nominated by the vice dean. The C/M coordinator forms the C/M team from the instructors of the C/M and ensures that all departments sharing in teaching the C/M are represented. The tasks and duties of the C/M team are specified by the vice dean.

The C/M team Members

- Actively participate in all C/M activities in all its phases (planning, implementation, evaluation and improvement).
- Act professionally within the team.

The C/M Coordinator

- Chairing the C/M team and arrange for team meetings (Pre and post C/M meeting).
- Suggesting the C/M team members in collaboration with related departments.
- Set the calendar of team meetings
- Supervise all the tasks and activities of C/M team.
- Ensure that the C/M is conducted as scheduled with adherence to the schedule and teaching plan
- Communicate regularly with class leader to monitor any deviation from the teaching schedule.
- Send his/contact information to class leader and liaise between the class leader and instructors.

The C/M Coordinator with the C/M team are responsible for:

- Carrying out routine C/M administration to:
  - Ensure the smooth running of the C/M
  - Ensure that all C/M documents are prepared and go through the appropriate approval procedures.
  - Deal with questions and problems related to the C/M conduction and management
  - Ensure that all educational materials, resources and facilities are ready when required for the students and teaching staff.
  - Work with the relevant units/committees to create efficient systems to support the C/M.
  - Ensure that the C/M is being run in accordance to general faculty and university guidelines

- Ensuring efficient delivery of the C/M by:

o Ensuring that all academic staff teaching the C/M are clearly and well informed by what is required from them through group and/or individual meetings as appropriate.

o Ensure that the students are oriented with the course learning outcomes, contents, teaching and learning strategies, assessment methods, required educational resources, student support and counselling and their roles in C/M evaluation and improvement.

o Clarifying the C/M requirements and the assessments methods for the students at the beginning of teaching every C/M

o Provide ongoing guidance to teaching staff of the C/M and deal with any problems that rise

o Provide ongoing guidance to the students and deal with any questions and problems

o Monitor the progress of the C/M and provide feedback to teaching staff and the students if required.

o Monitoring the commitment of the teaching staff to implementing the teaching strategies and the approved assessment methods mentioned in the course specification.

o Encourage instructors to exchange ideas and provide support for each other.

o Clarifying the requirements of students' attendance in the C/M and monitoring the extent of commitment

- Preparing and updating C/M documents and materials (with abidance to matrix of authorities)

o Update course specification based on previous course report, NCAAA templates and guidelines, and recommendations and feedback of quality and development unit.

o Put and follow up C/M timetable including all teaching and clinical training activities as bedside teaching and simulation session.

o Updates C/M matrix

o Updates student's study guide

- Updates exam blueprint
- Updates active teaching materials
- Implement and monitor C/M improvement plan
- Deal with any problems during C/M delivery by either providing feedback to the staff member concerned, or reporting the problem to the relevant unit/vice deanships.

- Assuring high quality student assessment

- Distribute the task related to assessment as exam preparation, approval, printing and photocopying.
- Ensure the abiding to the assessment guidelines issued by exam evaluation committee
- Preparation of the assessment blueprint according to the assessment policy.
- Preparation of the continuous and final assessment in accordance with the blueprint.
- Selection of the continuous assessment and final assessment tools and methods in accordance with the matrix stated clearly in course specifications.
- Agree upon distribution of marks and to be clearly stated in course specification.
- Review of the examination with the exam evaluation committee for final approval in the presence of the representative/s of the C/M team.
- Suggest the list of invigilators with related unit.
- Set clear plan for post exam tasks as marking and correction of exam papers, item analysis, discussion of the students' results, approval of the student grades and finally set a recommendation for improvement.

- Continuous quality improvement:

- Collect feedback on the C/M from a variety of sources, including students through electronic CES, teaching staff, and other staff, in order to identify areas for improvement, both in terms of syllabus and materials design and administrative systems.
- Measurement of achievement of CLOs and verify the students' achievement levels,

their grades distribution and their program completion rate in coordination with quality and development unit.

- Collect data essential for preparation of course report.
- Analyze the feedback and statistical data and report on the C/M.
- Identify training needs related to the C/M

Specific Tasks for C/M Team

- **Planning Phase**

This phase before starting the C/M. The C/M team conducts a pre-C/M meeting to ensure the implementation of improvements recommended in the previous year course report and the recommendations of Study plans and Curriculum Committee. The following issues are reviewed and discussed:

- Course specification
- Timetable
- Study guide
- Exam blueprint
- Distribution of active teaching strategies on different topics
- Ensure readiness of facilities and availability of resources
- The different forms of assessments and timing
- Implementation of the improvement plan
- Supplying items for exam bank (not less than 30% new items)

- Implementation Phase

Close follow-up and monitoring of C/M module implementation by C/M module team to assure that the C/M module is implemented as planned.

- Student assessment
  - Prepare the exam as planned in the exam blueprint weighted and aligned with CLOs with adherence to guidelines for item writing.
  - Management of examination process

- C/M module evaluation phase
- By the end of the C/M the C/M team finalizes the course report and course file to be submitted to the quality and development unit.
- For completion of C/M report the C/M coordinator:
  - Distributes the CES and analyses its of results
  - Receives students results and grades
  - Receives item analysis
  - Together with the team measures the achievement of CLOs
  - Holds the post-C/M team meeting to discuss the following:

- Exam results
- Results of item analysis and performance of items in the exam
- The achievement CLOs
- The obstacles faced during conduction of the C/M/module
- The areas of improvement
- Priorities for improvement
- The improvement plan and task distribution.

Approval

- The C/M coordinator of integrated modules submits the course report to the head of academic affairs for approval and uploads it in the course file on the google drive.

Reporting

- The C/M coordinator reports on the planning, implementation and evaluation of the C/M to related Vice deanships, unit or committees.
- Reporting to the quality and development unit.
- Reporting to the programs and study plans committee.

Related Parties

- Academic Affairs and distance education Unit
- Timetables and Examination Unit
- Exam evaluation unit
- Academic Advising Unit
- Year coordinators
- Programs and Study plans committee
- Quality and development Unit
- Measurement and Evaluation Unit
- Learning Resources Unit

Program Quality Assurance and Review Cycle:

Course report cycle (Figure 2)

At the end of each course, the course coordinators submit the course files and course reports on the NCAAA forms. The minimum requirements for annual course evaluation should include a summary and analysis of the final marks of students with comments on grade distribution, item analysis, measurement of the achievement course learning outcomes (CLOs), effectiveness of planned teaching and assessment strategies for CLOs, course evaluation by students and other evaluators, and an action plan for improvement that may include rising issues or proposals for change.

1- Course reports are prepared by the course coordinators on NCAAA forms, revised and approved in the post-module departmental / module team meeting and submitted to the Quality and Development unit.

2- In the vice deanship of quality and development; Quality and Development unit revises the submitted course reports and check their completion and prepares a collective report on the plan of improvement in the submitted reports.

3- The collective report and all course reports are approved by the program coordinator and raised to the faculty council.

4- The faculty council discusses and approve the collective report submitted by the quality and development vice deanship in addition to the post module meeting minutes of the departments and the module teams. The approved collective report and the course reports are then submitted to the deanship of development and quality.

5- The deanship of development and quality revises all the submitted reports and ensure that they fulfill the requirements of program accreditation and then submits them to the higher standing committee of academic accreditation and quality assurance.

6- The higher standing committee of academic accreditation and quality assurance revises the course reports and ensures the fulfillment of the CLOs and send its recommendations to the deanship of quality and development.

7- The deanship of development and quality sends the recommendation to the program coordinator for follow up.

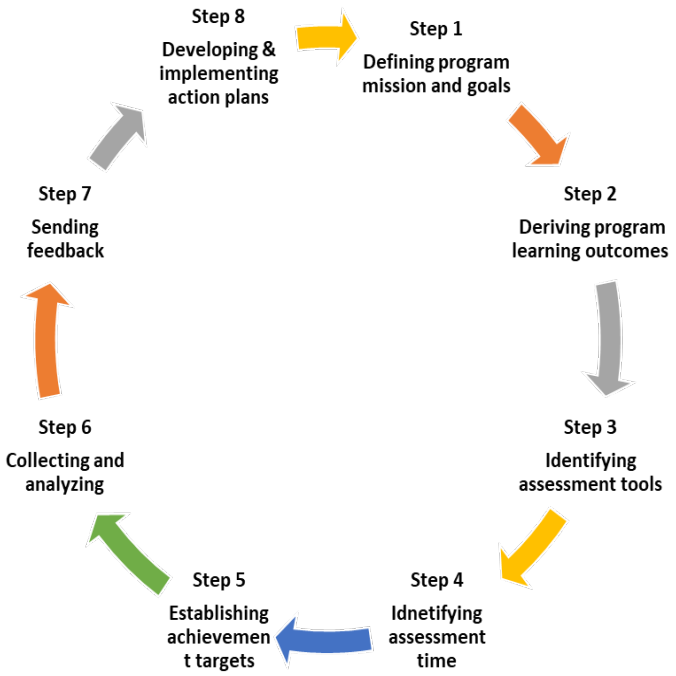
8- The program coordinator sends the recommendations to the concerned departments, module teams, units and committees for execution, follow up of implementation of the improvement plan with supporting entity if needed and the results are recorded in the course report of the next academic year.

Figure (2): Cycle of Course Report

2. Program Level

The quality management of the program is implemented through the PDCA cycle and monitored on a regular basis using an appropriate evaluation mechanism in order to support the continuous improvement of program and its activities and ensure that it is achieving its mission, goals and learning outcomes Fig (3).

Figure (3): Steps of the Program Assessment Process.



Annual Program Report cycle (Figure 4)

1- The course coordinators submit the finalized approved course reports to the quality and development unit (approved in the post module meeting).

2- The vice deanship of quality and development forms a team and puts and approves the operational plan for writing the annual program report (APR). The operational plan encloses the distribution of tasks, the coordination of meetings, writing and finalization of the APR. The APR summarizes the quality of the program performance and sets the action plans for improvement of the educational process and other processes.

3- The vice dean of quality and development revises and approves the APR and submits it to the program coordinator for approval and submission to the faculty council.

4- The faculty council discuss the APR, approves it and submits it to the deanship of quality and development.

5- The deanship of quality and development revises the APR and ensures its fulfillment for the requirement of program accreditation and submits it to the higher standing committee of academic accreditation and quality assurance.

6- The higher standing committee of academic accreditation and quality assurance revises the completion of measurement of the PLOs and sends its recommendations to the deanship of quality and development.

7- The deanship of quality and development sends the recommendations to the program coordinator and follows their implementation.

8- The program coordinator sends the recommendations to the concerned entity.

9- The quality and development unit follows the execution of the improvement plans and the percentage of achievement of the improvement plans is reported in the APR of the next year.

Figure (4): Annual Program Report cycle

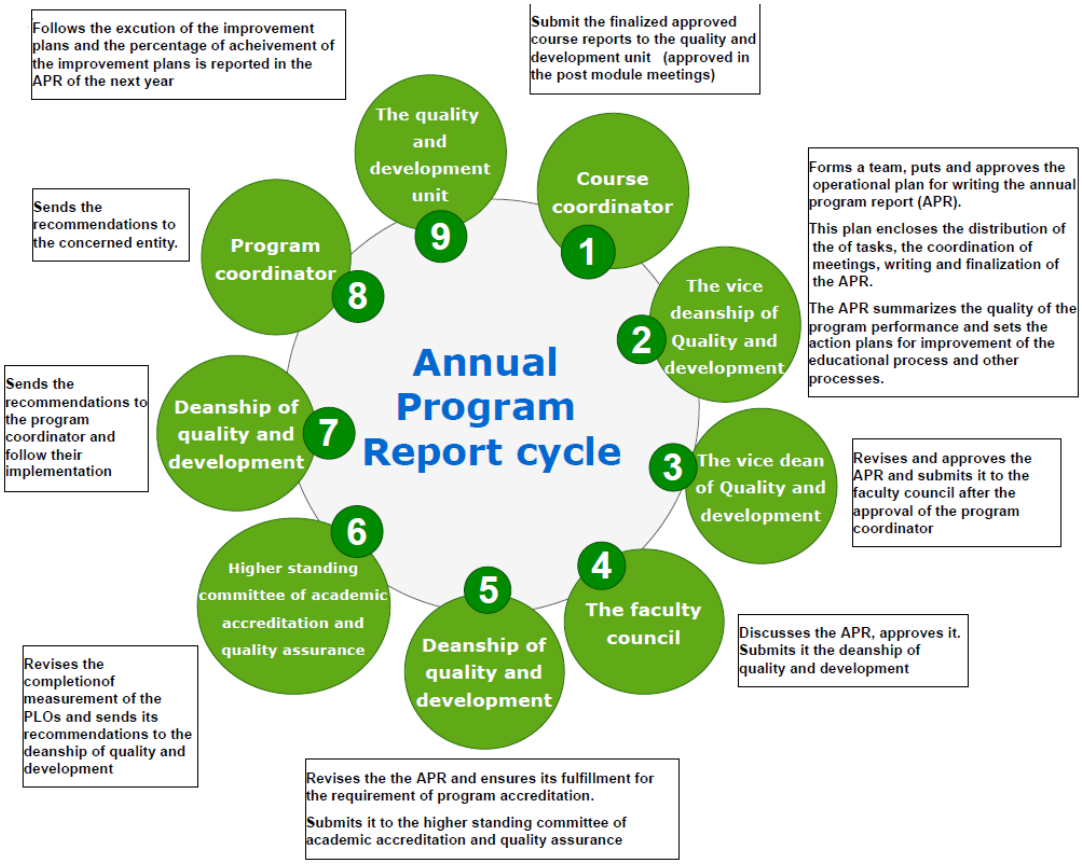


Table (2) The quality assurance activities at the program level are presented in table (2) with the specified by time.

Table 2: The Quality assurance Procedures at the course and Program level

Activity Name	End of Course	Annually	Responsibility
Course Evaluation Survey	√		Course coordinator & MEU
Post Module Meeting	√		Module coordinator and module team

Course Report finalization	√		Module coordinator and module team
Course File Submission	√		Module coordinator
Student Experience Survey		√	MEU
Program Evaluation Survey		√	MEU
Staff Satisfaction Survey		√	MEU
Employer Evaluation Survey		√	Program coordinator & MEU
Alumni Evaluation Survey		√	Alumni Unit and MEU
Academic Advising Survey		√	Academic advising Unit & MEU
Operational Plan report		√	SPU
Program KPI Report; Preparation and Analysis		√	MEU
Annual Program Report Preparation		√	QDU & MEU
Annual Program Report Revision		√	Deanship of D&Q
APR and Course Reports approval		√	FMd council
Actions Plan Preparation and Distribution		√	QDU
Actions Plan Execution Assessment		√	QDU

Table (3): *Timeframe of Program Evaluation*

Activity Name	*Monthly*	*Start of the Course*	*End of the Course*	*Annually*	*Mid cycle (Every 3/4 years)*	*Every 5 years*	*Every 6 years*
Units and committee meetings	√						
Departmental council meetings	√						
Faculty council Meeting	√						
Pre-module Team Meeting		√					
Course Files		√	√				
Course Evaluation Surveys			√				
Course Reports		√	√				
Post-module Team Meeting			√				
Needs Assessment and Checking the Resources				√			
Teaching/training Plan and Schedules				√			
Surveys (SES, PES, AES, EES, SSS-Ac, SSS-Ad, AASS)				√			
Program KPI Report and Analysis				√			
Operational plan Report and Analysis				√			
Stakeholders' surveys Report and Analysis				√			

PLOs & GAs measurement, analysis, report finalization with the improvement plan				√			
APR & the Improvement Plan				√			
Course reports and APR Revision/Recommendations by Deanship of D&Q				√			
Improvement Plan Distribution, Execution and Assessment				√			
Advisory committee meetings (≥2) and recommendations				√			
Independent Program Review (SSRP)							√
Review of Program & course Specifications and LOs and study plan					√ *(Internal review) (Minor change)*		√ (External Review) Major Change
Program mission, goals, GAs and operational plan						√	
Program SWOT Analysis Preparation and Reporting						√	

Self-Evaluation Scale					√		√
Self-Study Report of the Program (SSRP)							√

Table (4): Program Evaluation Matrix

Evaluation Areas/Aspects	Evaluation Sources/References	Evaluation Methods	Evaluation Time
Effectiveness of teaching and assessment methods	Program leaders, Students, Alumni, faculty, employers	Exam results and Course reports CES Post module meeting Program leaders-students meeting Interviews Peer review (Academic staff peer review, Students' peer review)	End of each course Annually
		PLOs achievement APR Program leaders-students meeting PES AES SSS-AC EES Meetings and interviews National exam results (SMLE, Progress test) SES	Mid of the program

Learning resources	Program leaders, Students, Alumni, faculty, employers	Course reports CES Post module meeting Program leaders-students meeting APR PES AES EES SSS-AC SES	End of each course Annually Mid of the program
Effectiveness of Leadership	Program leaders Academic Staff Admin staff	Staff performance Evaluation forms. Dean, Vice deans, Head of department, Academic staff members evaluation surveys. SSS-AC SSS-AD	Annually
Overall quality of the program	Students, Graduates, Alumni, Faculty, Program leaders, administrative staff, Employers, Advisory committee, independent reviewers	Course reports APR Operational plan report KPIs reports Program goals report PLOs and graduate attributes report Stakeholders survey report Focused group discussion	Annually

		Visits to training sites Advisory committee meetings	
Partnerships	Program leaders, academic staff, students, advisory committee	APR, Course reports Operational Plan Stakeholders' surveys Visits to training sites Advisory committee meetings	Annually

Table (5): Role of MBSS program Staff and Students in Planning, Quality assurance and Decision making

	Teaching staff	***Employee***	***Students***
Planning	Involved in formulation of program mission, goals, graduate attributes Involved in preparation program specification Participation in preparation of course specifications Head and member in department council, units and committees Participate in measuring PLOs - CLOs	Members in MBBS program Units and Committees Share in preparation of SWOT analysis (strategic and operational plan) Providing feedback and proposals for improvement	Students are members in the following units & committees: • Faculty Advisory committee • Students' advisory committee • Academic advising unit • Programs and study plan committee • Community service and students' activities unit and clubs.

Quality Assurance	Feedback through meetings and academic staff satisfaction survey Members in Accreditation committees Members in Q& D vice deanship units.	Admin- staff and technicians satisfaction survey. Members in Accreditation committees	Students share in evaluation of quality of courses and program and share in developing of improvement plans through various surveys: CES, PES, AES, Academic advising survey, mission & program goals survey, SES preparation
Decision Making	Faculty council members (faculty leaders) Committees Academic department councils Course coordinators and module team members Participate in designing improvement plans (course report, APR, operational plan report, KPI report) Participate in in reviewing and improvement of the study plan	Members in MBBS program Units and Committees Share in preparation of SWOT analysis Providing suggestions for improvement Provide requests for improvement of facilities and purchasing equipment	Students share in decision making through: • Students' advisory committee • Initiation of different students' clubs • Designing annual community service plans and students' activities • The priorities for improvement

Six-Year periodic Evaluation of the Quality of the MBBS Program

The program follows a set of procedures to manage its quality assurance according to specific schedule. It starts from planning to implementation and passing through performance measurement and evaluation of the achieved results that lead to review and improvement to start a new cycle.

The program follows a set of practical steps to conduct the annual cycle to ensure its quality according to a specific time frame and specific procedures. It proceeds from developing plans that enable the achievement of its mission and goals, passing through the implementation processes in accordance with the roles, responsibilities, tasks and powers, and finally evaluating the performance through the use of the various data received from the various activities, which lead to the review and development of annual improvement plans in order to achieve the mission and objectives of the program.

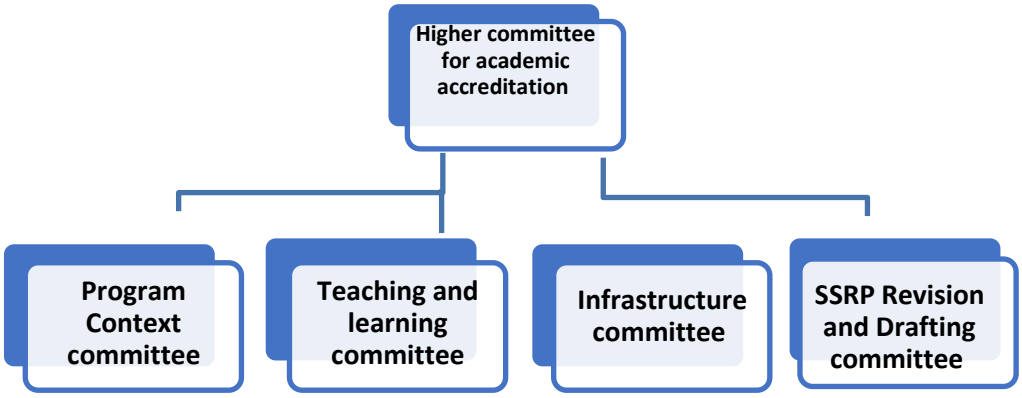
The program conducts a comprehensive periodic evaluation every 6 years after completion of the program cycle and prepares reports about the overall level of quality, with the identification of points of strength and weakness; plans for improvement; and follows up its implementation. It is a systematic evaluation for all aspects of the MBBS program, including study plan, and program learning outcomes, policies, academic services, and resources for improvement based on changes in healthcare sector environment and stakeholder perceptions.

The program also performs quality control audit every 3-4 years (mid of the program) based on results of stakeholders' surveys, operational plan reports, APR, advisory committee recommendations and in accordance with updates in the National Qualifications Framework, the requirements of the NCAAA and SAUDIMEDs framework with abidance by the matrix of authority approved by UT.

In parallel with the updating of the university strategic plan every 5 years, the program revises its mission and goals to ensure consistency with the faculty and university mission and goals and updates its operational plan.

In order to maintain the quality of the MBBS program for long term, a self-assessment should be carried out to the program every six years to ensure that it remains in accordance with the re/accreditation requirements of the organization. The self-evaluation process involves a retraction from the continuous process and a revision of all areas of the program based on present developments during a specific period, and on the potential changes that have occurred in the environment in which the students are being prepared to work. The Quality and Development Vice Deanship organizes 4 committees (Fig 5, table 6) headed and directed by the "**Higher Committee for Academic Accreditation"**.

Figure (5): Academic Accreditation Committees



The 4 committees are responsible for the evaluation of the adoption of best practices and quality assurance in the six program accreditation standards developed by the National Commission for Academic Accreditation and Evaluation (NCAAA) and preparing the SSRP.

Table (6): Academic Accreditation Committees

	NCAAA Standard	Responsible Committee
Standard 1	Mission and Goals	

Standard 2	Management of Program Quality Assurance	The Program Context Committee
Standard 3	Teaching and Learning	Teaching and Learning Committee
Standard 4	Students	
Standard 5	Teaching Staff	
Standard 6	Learning Resources	Learning resources, facilities, and equipment Committee
All standards	All standards	SSRP Revision and Drafting Committee

Tasks of academic accreditation committees

A- The Program Context Committee

1. Ensuring that the mission and goals of the program are consistent with the mission and goals of the faculty and university.
2. Reviewing the awareness of the beneficiaries with the program's mission and goals and the mechanisms, regulations and administrative flowchart structures within the program
3. Monitoring the progress towards achieving program goals
4. Reviewing the different quality processes in the program.
5. Measurement of KPIs related to the standards and formulation of the improvement plan, and follow up the implementation of the improvement plan
6. Preparation of the necessary evidences and documents to prove the good practice as stipulated in the standard 1 & 2 guide.
7. Preparing the self-evaluation report for standard 1 &2.
8. Participating in preparing the program self-study report.

B- Teaching and Learning Committee

1. Preparation of the necessary evidences and documents to prove the good practice as stipulated in the standard guide 3,4, and 5.
2. Measurement of KPIs related to the standards (3-5) and formulation of the improvement plan, and follow up the implementation of the improvement plan.
3. Following up the teaching and assessment processes, students' achievement and graduate employability
4. Following up on the preparation, submission and revision of the Academic Advising Unit Report
5. Following up on the implementation of new faculty members preparation program
6. Following up on the preparation of the faculty member training plan and training report.
7. Following up on the submission of the training workshop's impact report on the trainees.
8. Following up on the preparation and approval of the annual scientific research plan and submission of the annual report in coordination with the Scientific Research Committee.
9. Checking the update of teaching staff database and follow-up on the updating of the teaching staff CVs.
10. Following up on the preparation and approval of the annual community services plan and the submission of the annual report in coordination with community services committee.
11. Measurement of KPIs related to the standard and formulation of the improvement plan, and follow-up on the implementation of the improvement plan.
12. Preparation of the necessary evidences and documents to prove the good practice as stipulated in the standard guide.
13. Preparing the self-evaluation report

14. Participating in preparing the program self-study report.

C- **Infrastructure Committee**

1. Following up on provision of the appropriate learning resources according to the national/international standards and submitting reports to faculty administration.

2. Following up on provision of appropriate facilities and equipment resources according to the national/international standards and submit reports to faculty administration

3. Following up on compliance with safety and security precautions in the faculty facilities.

4. Measurement of KPIs related to the standard and formulation of the improvement plan, and follow up the implementation of the improvement plan.

5. Preparation of the necessary evidences and documents to prove the good practice as stipulated in the standard guide.

6. Preparing the self-evaluation report.

7. Participating in preparing the program self-study report.

D- **SSRP Revision and Drafting Committee:**

1- Collection of all six standards and their evidence from the other committees.

2- Revision of SSRP and successive iteration of the all standards

3- Drafting and finalizing the SSRP.

Key Performance Indicators (KPIs) and Benchmark

They are specific forms of evidence used by the faculty to provide evidence and measure the of quality performance. The KPIs are one of the most important tools for assessing the quality of academic programs according to the criteria and rules of the NCAAA, and are among the most prominent practices that contribute to decision-making and follow-up processes and continuous development and improvement.

The NCAAA has identified 17 KPIs at the program level all of which are in line with the evolving program accreditation standards. These indicators are the minimum to be periodically measured, and the academic program can use additional performance indicators if it believes they are necessary to ensure the quality of the program. One program KPI is added to the 17 KPIs of the NCAAA as it is believed to add valid information for assessing and evaluating the performance of the MBBS program.

1. Levels of Each KPI

It is expected that the program measures the KPIs with benchmarking using the appropriate tools, such as (Surveys, Statistical data, etc.) according to the nature and objective of each indicator, as well as determining the following levels for each indicator:

1.1. Actual performance

Refers to the finding outcome determined when the KPI is measured or calculated. It represents the actual reality of the present situation. A finding benchmark is also an internal benchmark.

1.2. Targeted performance level:

Refers to the anticipated performance level or desired outcome (goal or aim) for a KPI. A target benchmark is also an internal benchmark.

1.3. Internal reference (Internal benchmark):

Refer to benchmarks that are based on information from inside the program or institution. Internal benchmarks include target or finding benchmark data results from previous years.

1.4. External reference (External benchmark)

Refer to benchmarks from similar programs that are outside the institution, it refers to other institutions (national or international).

1.5. New target performance level

Refers to the establishment of a new or desired performance level or goal for the KPI that is based on the outcome of the KPI analysis.

KPI Analysis:

Refers to a comparison and contrast of the benchmarks to determine strengths and recommendations for improvement.

2. Selection of KPIs based on:

1. The 17 NCAAA Program KPIs
2. MBBS Program KPI

A report is prepared annually describing and analyzing the results of each indicator (including: performance changes and comparisons according to sites and gender) with precise and objective identification of strengths and aspects that need improvement.

For each KPI, an acceptable target level to be achieved is set based on the program strategic goals, the comparative data of the internal and external benchmarking, with the intention to gain a performance growth with a minimum rate of 5% annually *(UT procedure guide for benchmarking and independent review)*.

For each KPI the following values are measured:

Target KPI: which is determined according to the KPIs measurements of the internal and external benchmarking. Hence, it is the new target KPI of the former academic year.

Actual KPI: which is the actual level of the current year performance.

***New target KPI*:** which is determined in consideration of the actual benchmark.

- For the achieved target KPI level, a holding of the new targeted level is kept for an additional year to establish and maintain the good practice before setting an increment of the new target KPI.
- A 5% growth rate is considered acceptable improvement of the practice when setting a new target KPI level.
- If the target is not achieved so the previous target will be held as a new target for the year after, with investigating the reasons and delineating a plan for improvement to reach the targeted performance.

3-Sources of data:

✓ The MBBS program operational plan reports.
✓ Reports on stakeholder surveys
✓ Program evaluation survey (PES).
✓ Courses' evaluation surveys (CES).
✓ Student experience survey (SES).
✓ Academic staff Satisfaction survey (SSS-AC)
✓ Administrative staff satisfaction survey (SSS-AD).
✓ Employer Evaluation survey (EES).
✓ Stakeholder satisfaction with learning resources report.
✓ Official students' records obtained for the university secured internal system (e-register).
✓ Saudi Commission for Heath Specialties (SCFHS) internet.

- ✓ Students marking of the National progress test, Qassim University.
- ✓ Records from Ministry of Health, National Civil Services, and social insurance of the MBBS program graduates.
- ✓ MBBS program staff university records from human resources.
- ✓ MBBS program records from the vice deanship for postgraduate and research.
- ✓ Scopus and ISI databases.

4-*Data analysis methodology:*

All data analysis is performed using Microsoft® Excel® for Microsoft 365.

KPIs are presented as one of the following:

- Weighted mean and scored on a scale of 5 considering (3/5) as a cut-off level of satisfaction
- A proportion
- A percentage of performance.

The outcome of all KPIs values is presented as a percentage to calculate the final performance of the MBBS program indicators for the academic year of interest. Rates of growth (increment) or decline (decrement) are calculated in the comparative and trending analysis of the current performance with the internal and external benchmarking.

Figure.6: KPIs annual assessment cycle.

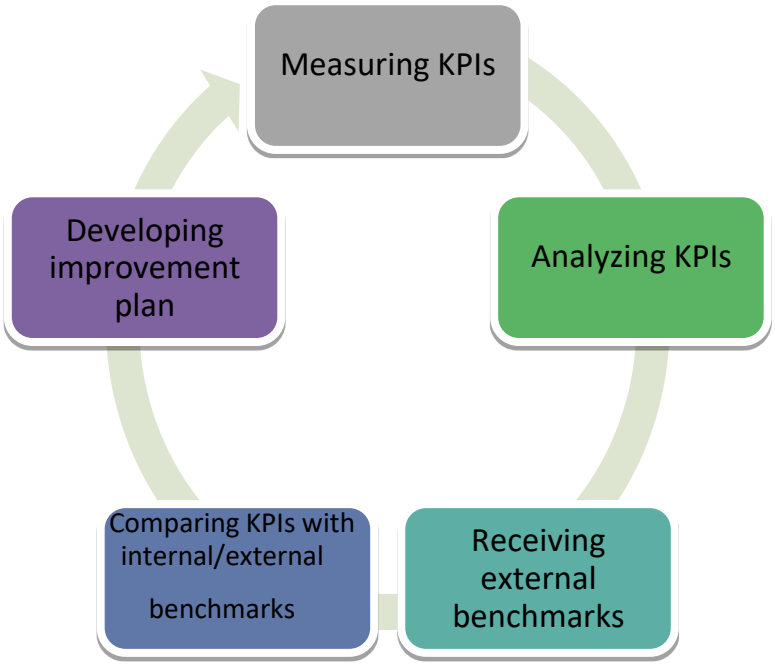


Table (7): NCAAA & PROGRAM KPIs, Objectives, Polarity, and Method of Measuring Indicators and the Target

Code	Indicator	Goal	Time for measurement	Data Measurement Provider	Measurement Responsibility	Measurement Tools
KPI-P-01	Percentage of achieved indicators of the program operational plan objectives	Measuring the quality of program performance in all axes	Annually at the end of academic year	All units & committees	Head of SPU	Operational plan template Completion rate report template
KPI-P-02	Students' Evaluation of quality of learning experience in the program	Measuring the educational quality of the program	Annually at the end of academic year	Head of MEU	Head of MEU	Program Evaluation Survey

KPI-P-03	Students' evaluation of the quality of the courses	Measuring the educational quality of the program	Annually at the end of academic year	C/M coordinator	Head of MEU	Course Evaluation Survey
KPI-P-04	Completion rate	Measuring the educational quality of the program	Annually at the end of academic year	Head of the Academic Affairs Unit	Head of MEU	Statistical data and analysis
KPI-P-05	First-year students retention rate	Measuring the educational quality of the program	Annually at the end of academic year	Head of the Academic Affairs Unit	Head of MEU	Statistical data and analysis
KPI-P06	Students' performance in the professional and/or national examination	Measuring the educational quality of the program	Annually at the end of academic year	Program coordinator	Head of QDU Head of MEU	Statistical data and analysis of SMLE and progress test results

KPI-P-07	Graduates' employability and enrolment in postgraduate programs	Measuring the quality of graduates ‹characteristics, and the extent of employers› satisfaction, and the labor market's need for them	Annually at the end of academic year	Head of alumni unit	Head of MEU	Statistical data and analysis
KPI-P-08	Average number of students in the class	Measuring the quality of educational facilities	Annually each academic yea	Head of the Academic Affairs Unit	Head of MEU	Statistical data and analysis
KPI-P-09	Employers' evaluation of the program graduate proficiency	Measuring the quality of graduates ‹characteristics and employers›	Annually each academic year	Head of the Alumni unit	MEU	Employer Evaluation Survey

		satisfaction with them				
KPIP-10	Students' satisfaction with the offered services	Measuring the quality of support for students	Annually each academic year	MEU	MEU	Program Evaluation Survey
KPI-P-11	Ratio of students to teaching staff	Measuring the quality of education elements	Annually at the end of academic year	Head of Academic Affairs Unit	MEU	Statistical data and analysis
KPI-P-12	Percentage of teaching staff distribution	Measuring the quality of education elements	Annually at the end of academic year	Head of Academic Affairs Unit	MEU	Statistical data and analysis
KPI-P-13	Proportion of teaching staff leaving the program	Measuring faculty's satisfaction with the educational environment	Annually at the end of academic year	Program coordinator	MEU	Statistical data and analysis

KPI-P-14	Percentage of publications of faculty members	Measuring the quality of the axis of scientific research	Annually at the end of academic year	Head of Scientific Research Unit	Head of Scientific Research Unit	Statistical data and analysis
KPI-P-15	Rate of published research per faculty member	Measuring the quality of the axis of scientific research	Annually at the end of academic year	Head of Scientific Research Unit	Head of Scientific Research Unit	Statistical data and analysis
KPI-P-16	Citations rate in refereed journals per faculty member	Measuring the quality of the axis of scientific research	Annually at the end of academic year	Head of Scientific Research Unit	Head of Scientific Research Unit	Statistical data and analysis
KPI-P-17	Satisfaction of beneficiaries with the learning resources	Measuring the quality of learning resources	Annually at the end of academic year	Multiple sources	MEU	Staff Satisfaction Survey (SSS) Program Evaluation Survey (PES) Student Experience Survey (SES) Course Evaluation Survey (CES)

KPI-P-18	Staff satisfaction rate with various services offered by the MBBS program.	Measuring academic and administrative staff satisfaction with the working environment and the quality of support	Annually	MEU	MEU	Academic Staff Satisfaction Survey (SSS-AC) Admin Staff Satisfaction Survey (SSS-AD)

The target of the KPI is determined based on: The future plan for faculty strategic plan, internal and external benchmarking. Graduation in the target value is applied whenever the current values are far from the strategic targets

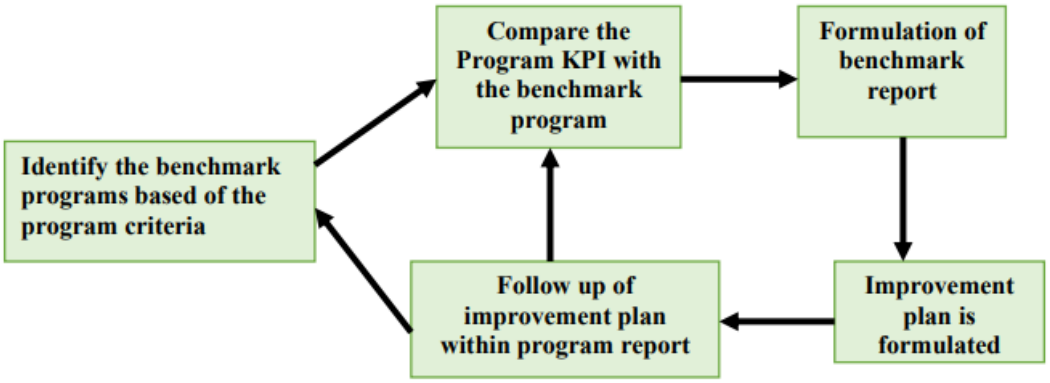
Benchmarking and Improvement Cycle

It is a systemic and continuous process for measuring the program performance by comparing it to another program within or outside this university to identify the causes of the gap and work to address them and reach the best performance. Benchmarking is a vital process for maintaining the high quality of performance of any program and ensure continuous quality improvement (Fig.4). It allows for comparing the performance of various aspects of the program with respect to the good practices recommended by the NCAAA.

The Importance of Benchmarking:

1. Rationalization of expenditures.
2. Providing continuous learning opportunities.
3. Provide an opportunity for the organization to move - internally and externally - towards better models.
4. Providing cooperation opportunities between local organizations or units.
5. Enabling senior management to answer a set of questions.
6. Adopting an organizational culture aimed at solving problems.
7. Assisting the foundation in precisely defining the gap between its performance and that of the leading institutions in its field of work.
8. It helps to provide the appropriate climate, and enhances the desire for leadership of the institution and its employees to adopt a policy of change towards all that is better and new.
9. Helping define critical processes, give them the necessary attention and priority in implementation, and actively contribute to developing individual and group creativity.
10. It actively contributes to increasing the chances of achieving additional benefits for the program.
11. The external focus of the benchmarking method creates external competitive measures that necessarily increase the efficiency and effectiveness of internal performance quality measures, and makes them more competitive.

Figure (7): KPI Improvement Cycle



Stakeholders Surveys

The relationship between stakeholder's satisfaction and program sustainable growth and success is investigated focusing on the importance of a firm's relationships with critical stakeholders that may lead to better performance, as program while integrating business and societal considerations create value for their stakeholders. However, it is of most importance that top management actively leads this approach and that the governance bodies of the organizations support and check that this really happens. There are different types of surveys for all program stakeholders.

Main Principles

There are a number of general principles that should be followed if student surveys are to be as useful as possible.

1. It must be made clear to students that all survey responses are anonymous.
2. Surveys should include common questions to enable them to be used for comparisons within departments and between courses.
3. Some open-ended questions should be included to permit respondents to comment on additional matters of concern.
4. In addition to a number of individual items relating to matters considered important, surveys can include one or two summary items that can be used as general quality indicators.
5. To be used for benchmarking quality between programs the surveys should be distributed in similar ways and at similar times and comparisons made between comparable institutions.
6. Questions should be consistent over time (normally at least three years) so that valid trend data can be obtained.
7. The validity of responses depends on having a reasonable response rate. Normally at least 50% is essential. To encourage participation:

a) Surveys should not be overused.

b) Use should be made of the responses, and summary reports and indications of action taken in response made available.

c) The surveys should not be too long (a maximum of 20 to 25 items plus a small number of open- ended items is usual).

Recommended Surveys

Students and staff are the principal customers of the education system and surveys of their opinions are one of the most important sources of evidence about quality in higher education. Other stakeholders should be considered, they can provide very good insight about the outcomes of the program. They can provide very useful suggestions for improvement that should be considered in the quality cycle for improvement as applied to individual courses, programs, and institutional planning.

Type of surveys used:

1. Course Evaluation Survey (CES):

a) A course evaluation survey is distributed at the end of each course. It is recommended that this survey be distributed in each course once each year.

b) The survey does not directly assess the quality of teaching by individual instructors. However, the evaluation of the course is seen as a reasonable measure of the quality of teaching in a way that minimizes personal issues that could inhibit responses from students.

c) The survey asks questions about a number of aspects of each course. The final question is intended to provide a summary question that might be used as a general quality indicator.

2. Student Experience Survey (SES):

a) This is intended as a general survey that is distributed to all students mid-way through their program (in between phase 2 and phase 3) of MBBS program.

a) The survey deals with the student's life at the institution including both major elements of the program in which they are enrolled and a number of general items relating to services and facilities. As for the other surveys the final question is a summary item that might be used as a general quality indicator.

3. Program Evaluation Survey (PES):

b) This survey is conducted annually. It is intended for use at the time students have finished their program and are about to graduate. It is recommended to be distributed shortly before final 6th year classes are finished so their opinion of the total program at that stage can be assessed.

c) The questions include a number of items about the program itself together with some items similar to those in the SES that deal with their life as a student at the institution. As for the other surveys the final question is a summary item that might be used as a general quality indicator.

4. Alumni Evaluation Survey (AES)

a) A survey of alumni is conducted annually. The target alumni are those graduates from for the last year earlier and 3 years earlier.

b) This instrument captures quantitative rankings about their experience in the program and PLOs, their achievement in SMLE, enrolment in post-graduate program and employability.

5. Staff Satisfaction Surveys (SSS)

These are 2 surveys; Academic Staff Satisfaction Survey (SSS-AC) and Administrative Staff Satisfaction survey (SSS-AD)

a) These 2 surveys are conducted on annual basis aiming to assess the staff satisfaction about the faculty, program and services offered to them.

b) Encouraging work performance is a strategic and key task, reflected in employees' motivation and creating conditions to express their creativity, as well as an adequate way of evaluating and rewarding work results.

c) In the context of improving efficiency, an important precondition is continuous measuring employee satisfaction.

d) The results of these surveys are directed primarily at designing processes and activities, as well as defining short-term and long-term measures to improve satisfaction and motivation.

6. Employers Evaluation Survey (EES)

This survey is conducted on annual basis aiming to assess the level of satisfaction among employers about the outcomes of the program and also used to assess the PLOs.

7- Program leaders and academic Staff Evaluation surveys

These are 4 surveys conducted on annual basis aiming to assess the level of satisfaction among staff members about the performance of the program leaders and academic staff for feedback and continuous improvement.

a-Dean Evaluation Survey

b- Vice dean Evaluation Survey

c- Head of Department Evaluation Survey

d- Academic Staff Evaluation Survey by Head of the Department

e- Peer evaluation form.

8- Academic Advising Satisfaction Survey

The primary goal of Academic Advising is to assist the students in identifying and achieving their educational, personal, and career goals. It will help them develop as a self-directed learner, explore resources, and assist in getting the most during their stay at University of Tabuk. Academic Advising is a continuous and consistent process. The success of this program is based on a good working relationship between the Advisor (Faculty) and Advisee (Student). This requires frequent, accumulated personal contacts between advisor and advisee. Both the advisor and the student share the responsibility of actively participating in the process of academic advisement.

Response Scale

It is recommended that each item in the surveys be responded on a five-point scale. The recommended scale is:

1. Strongly agree (5)
2. Agree (4)
3. Neutral (or undecided) (3)
4. Disagree (2)
5. Strongly disagree (1)

Table (8): Stakeholders' Survey Plan

A-Students

Survey	Area of Evaluation	Target Group	Distribution Responsibility	Distribution Timing	The Uses of the Survey	The Target of the Response
CES	Course quality	Students	C/M coordinator	End of the module	-KPI-P-03 Average student overall rating of course quality on five-point scales -Course report	Applying to all program courses With a response rate of not less than 50% of the sample
SES	The student's academic life in the educational institution, including the basic components of the program in which the student is registered	Students who have passed half of the program's duration	MEU	MEU	KPI-P-10 Student satisfaction with services provided KPI-P-17 Beneficiaries' satisfaction with learning Resources	A response rate of not less than 50% of the sample

PES	Final year students' satisfaction with program, services, facilities, and program management	Final year students of the program	MEU	MEU	KPI-P-02 Students' evaluation of the quality of learning experiences in the program KPI-P-10 Student satisfaction with services provided KPI-P-17 Beneficiaries' Satisfaction with Learning Resources	A response rate of not less than 50% of the sample
Academic Advising SS	Students' satisfaction with the academic advising service and academic advisor	All Students	Academic advising Unit	MEU	KPI-P-10	A response rate of not less than 50% of the sample

B- Alumni

Survey	Area of Evaluation	Target Group	Distribution Responsibility	Distribution Timing	The Uses of the Survey	The Target of the Response
AES	Alumni satisfaction with the program	Alumni	Alumni unit	At least 6 months after their graduation	KPI-P-02 Students' evaluation of the quality of learning experiences in the program KPI-P-10 Student satisfaction with services provided	With a response rate of not less than 50% of the sample
EES	Employers' satisfaction with program outcomes	Employers		It is submitted to the employers one year after the student's graduation.	KPI-P-09 Employers' assessment of the competency of program graduates	With a response rate of not less than 50% of the sample

C-Teaching Staff

	Survey	The Purpose of the Questionnaire	Timing Uses
1	SSS-AC Staff	Measuring the extent of academic staff members' satisfaction with: ✓ Program management ✓ Organization environment ✓ Quality management ✓ Educational process ✓ Program mission ✓ PLOs ✓ Facilities and services ✓ Scientific research ✓ Community service	Annually KPI-P-18
2	Faculty council	• The extent to which the university's systems, policies, and regulations are applied • The extent of the ability to plan, develop, continuous improvement, and justice • Extent of an organizational environment that supports work within a framework of integrity and transparency	Annually Evaluation of program management
3	Dean of the faculty Vice deans of the faculty	The effectiveness of the leadership in the faculty	Annually Evaluation of program leaders
4	Head of academic Departments	The satisfaction with the performance of the head of the department	Annually Evaluation of program leaders

5	Academic department Councils	The effectiveness of the department council	Evaluation of program management

D-Employees

Survey	Area of Evaluation	Target Group	Distribution Responsibility	Distribution Timing	The Uses of the Survey	The Target of the Response
SSS-AD staff	Satisfaction with job, services, management	The employees and technicians	MEU	Annual	KPI-P-18	With a response rate of not less than 50% of the sample

Quality Procedures in MBBS program

1- Program Mission & Goals

Determinants	1. The MBBS program should have a clear and appropriate mission and have goals that are clear, realistic and measurable and support their application 2. The program mission and goals should be consistent with the those of University of Tabuk and the faculty of medicine 3. The program goals should be linked to the program mission 4. The program mission should be approved and widely publicized 5. The program mission should be consistent with the needs of the society and the national trends 6. The program mission & goals must be reviewed periodically with the participation of relevant stakeholders to ensure their consistency with the university and faculty mission and goals, with the needs of the society and the national trends and developed accordingly 7. The review process should enable the program management to perform major changes in the Program mission & goals.
Responsibilities	Vice dean of Q&D QDU, MEU, SPU
Scope	- Dean of faculty - All members of faculty council - Advisory committee - Program stakeholders ✓ Students ✓ Alumni ✓ Employers ✓ All faculty members (academic and administrative staff)
Procedure	Announcement of the new strategic plan of the university and faculty of medicine 1. Vice dean of Q&D forms a team to conduct workshops with program leaders and stakeholders to review and suggest updates for program mission and goals. 2. The QDU gather the drafts and formulates fewer drafts of the proposed (updated) program mission

	and goals ensuring clarity, appropriateness and alignment with faculty and university mission and goals. The draft of Program mission and goals are developed in the light of: ✓ The Mission, Vision and strategic Goals of the University of Tabuk and Faculty of Medicine ✓ KSA "2030 Vision". ✓ SWOT analysis (strengths and weaknesses of the program and opportunities and threats facing the program) ✓ The university and community need and expectations 3. The vice dean of Q &D presents the proposed program missions and goals on weekly academic activity day to all academic staff members and students' representative for discussion and feedback. 4. QDU gathers feedback and prepares the final draft. 5. The vice dean of Q & D presents the proposed program mission and goals in the advisory committee meeting for discussion and feedback 6. The MEU distributes an electronic survey with the proposed (updated) program mission and goals to all stakeholders (students, alumni, faculty staff members, employers) and analyses the results and submits them to QDU 7. The QDU finalizes the program mission and goals and prepares report with matrices of alignment 8. The vice dean of Q&D submits the updated mission and goals to the Faculty Council for approval. 9. Approved program mission and goals are submitted to the programs and study plans committee in UT for final approval 10. Vice dean of Q&D submits the report of alignment matrices to the Deanship of Development & Quality 11. The deanship of D & Q approves the report and matrices of alignment of program mission and goals with FMd and UT missions and goals 12. The strategic plan unit ensures wide publication of the program mission and goals through different channels 13. QDU ensures adherence to the procedure

Notes	**1-** Defined time for reviewing the program mission & goals ✓ Every 5 years: with the announcement of the new 5-years strategic plan of the university and faculty. **2-** The program mission must be consistent with the FMd and UT mission. ✓ The QDU ensures alignment of the program goals with the updated mission. **3-** The program goals should be aligned with the program mission ✓ The QDU ensures alignment of the program goals with the updated mission. **4-** The program goals should be aligned with the faculty and university goals ✓ The QDU ensures alignment of the program goals with the FMd and UT goals.
Records	1. Assignment of the review team 2. Meeting minutes of: • Review team meeting minutes • Advisory committee meeting minutes • Weekly academic day activity log • SPU meeting minutes • QDU meeting minutes • Faculty council meeting minutes for approval of program mission and goals • SPU meeting minutes 3. Report on survey analysis and results 4. QDU report
References	1- *Governance of the Strategic Plan Guide* 2- University of Tabuk updated strategic plan 3- Faculty of medicine updated strategic plan 4- SWOT analysis 5- Matrix of authority of study plans and academic programs 6- KSA "2030 Vision"

2- MBBS program operational plan.

Determinants	The program should develop an operational plan to achieve the program goals The goals should be aligned with faculty and university strategic goals
Responsibilities	Vice dean of quality and development: QDU, SPU & MEU Vice deanships and affiliated units.
Scope	All vice deanships and affiliated units All academic departments
Procedure	1- The vice dean of Q &D forms a committee for writing the operational plan from QDU, SPU and MEU. 2- The committee studies the following: ✓ The program mission and goals ✓ The faculty strategic plan ✓ Priorities of improvement mentioned in the achievement reports of the previous operational plan ✓ Plans of improvement linked to priorities of improvement for achievement of operational plan mentioned in the reports of different units/committees ✓ Plans of improvement and priorities of improvement mentioned in the APR and course reports ✓ Priorities of improvement mentioned in KPI reports and benchmarking ✓ Reports on Stakeholder surveys ✓ Graduate attributes and PLOs achievement reports ✓ Priorities of improvement mentioned in SES and SSRP if present 3- The committee links the priorities of improvement mentioned in all the reports with the program goals and the program operational plan through filling the form of linking the priorities of improvement with the strategies and objectives of the operational plan to be consistent with the initiatives of the faculty and university strategic plan. 4- Distribution of the priorities of improvement on the different units according to their scope and putting a timeframe for designing improvement plans for these priorities. 5- Each unit discusses the strategies and the priorities for improvement and proposes a plan for improvement and design a procedural plan for execution including the timeframe, responsibilities, the performance indicators, target benchmark, and required resources.

	6- The SPU gathers all the proposed plans and fill the form of preparation of the operational plan including the timeframe, responsibilities and target benchmark. 7- The vice dean of Q & D presents the operational plan to the advisory committee for discussion and recommendations 8- The Vice dean of Q &D presents the operational plan in the faculty council for discussion and recommendations 9- The SPU modifies the operational plan according to the received recommendations 10- The vice dean of Q & D submits the operational plan to the faculty council for approval 11- The SPU makes a list with the resources required to implement the operational plan in terms of facilities, learning resources and human resources and submits it to the dean of the faculty, who directs them to the concerned authorities and follows up the response to provide them. 12- Each unit works to implement its related strategy in the operational plan 13- Regular reports are submitted to the vice deans of the related units including points of strengths and areas for improvement. 14- The vice deanships submit reports of achievement with the related evidences to the head of SPU who submits a periodic report on the level of achievement to the strategic plan committee in UT 15- The SPU performs a self-evaluation of the achievement of the objectives through comparing the actual benchmark with the target benchmark 16- The head of the SPU submits an annual report on the progress of achievement of the objectives in the operational plan based on the reports submitted by different units associated with evidences 17- The report is discussed in the advisory committee and in the faculty council and finalized by the SPU based on their recommendations. 18- The report is submitted to the faculty council for approval and directing the development of appropriate improvement plans.
Records	Operational plan Action plans of the units Reports of the progress and achievement of related objectives by different units Report on the progress and achievement of the operational plan Meetings minutes: ✓ Committee of writing the operational plan ✓ Advisory committee

	✓ Faculty council ✓ Units and committees
References	1- *Governance of the Strategic Plan Guide* 2- University of Tabuk strategic plan 3- Faculty of medicine strategic plan 4- Tasks and duties of councils, units and committees

3- Measuring Program goals.

Determinants	1. The program should annually monitor and measure the program goals and assess the extent of their achievement through specific performance indicators 2. The program should take the necessary actions for performance improvement based on the results of measurement and benchmarks
Responsibilities	- Vice dean of Q & D - SPU, MEU, QDU
Scope	- Faculty dean - UT-strategic planning unit - Faculty deanship and affiliated committees - Vice deanships and affiliated units - Academic departments - Faculty administration and affiliated units - Program stakeholders: Students, Alumni and employers - Advisory committee - Faculty council
Procedure	1- The QDU aligns the plan of measurement of program goals with the operational plan of the faculty and university to ensure consistency 2- The internal benchmark is considered to be the previous year measurements. 3- The vice dean of Q&D approves the plan for measurement of program goals 4- Retrieval of operational plan KPI measurements from their quarter annual reports 5- Measurement of the program goals according to the approved measurement plan. 6- Preparation of annual report on the achievement of program goals with proposed improvement plan 7- Approval of the report by the vice dean of Q &D 8- Discussion of the report in the advisory committee meeting 9- Discussion and approval of the report in faculty council meeting 10- Sending the improvement plan to vice deanships and academic departments 11- Distribution of tasks in departments and units according to the responsibilities defined in the improvement plan

	12- Implementation of the improvement plan 13- Follow up on results of improvement in next year reports
Records	1. Meeting minutes of advisory committee 2. Meeting minutes of faculty council 3. Approved annual program goals report 4. Official emails to vice deans, head of academic departments and faculty manager with the improvement plan.
References	1. University of Tabuk 2nd strategic plan 2. Faculty of medicine 2nd strategic plan 3. Faculty of Medicine operational plan 4. MBBS program operational plan and report 5. UT benchmarking procedural guide

4- MBBS program Graduates' Attributes

Determinants	1- The MBBS program identifies its graduate attributes (GAs) that are consistent with its mission, and aligned with the graduate attributes of UT 2- The GAs are approved, publicly disclosed, and periodically reviewed. 3- The GAs are consistent with the requirements of the National Qualifications Framework (NQF) and with academic, professional, and health sector requirements. 4- The program applies appropriate mechanisms and tools for measuring the graduate attributes, and verifying their achievement according to specific performance levels and assessment plans.
Responsibility	Head of Programs and study plans unit
Scope	- Program coordinator - Members of Faculty council - Programs and study plans unit - Advisory committee - Vice deanship of Q & D: MEU, QDU - Academic staff members - Program stakeholders
Inputs	- Program mission, goals, PLOs - UT graduate attributes - National qualification framework - SAUDI-MEDs framework - Reference comparison e.g CanMeds framework
Procedures	1- The head of the programs and study plans committee determines the members of the work team (the committee members, head of departments, experts in medical education) 2- The team is approved by the vice dean 3- The assigned team reviews the program mission and goals and UT graduates' attributes 4- The team reviews the previous GAs and the notes on them. 5- The team reviews the NQF criteria for level 7, the last updated NCAAA forms and last updated SAUDI-MEDs framework.

	6- The team reviews the GAs of peer national and international programs, the new development in the medical field and healthcare sector requirements. 7- The team formulates the GAS consistent with UT GAs, the program mission, PLOs, NQF and Saudi MED framework. 8- The GAs are presented to and discussed with the faculty council 9- GAs are adjusted by the assigned team according to the notes that are received from the faculty council 10- The GAs are presented to the advisory committee 11- The GAs are adjusted by the assigned team according to the notes that are received from advisory committee 12- The vice dean sends the GAs to the vice dean of Q & D for collecting feedback on proposed GAs from program stakeholders 13- The MEU distributes an electronic survey with the proposed GAs to all stakeholders (students, alumni, faculty staff members, employers) and analyses the results. 14- The programs and study plans committee receives the analysis of surveys and finalizes the MBBS program GAs and prepares report with matrices of alignment with UT GAs and MBBS program learning outcomes to be applied as GAs measurement plan. 15- The final GAs and matrices of alignment are presented to and approved by the faculty council 16- The GAs are announced and included in the program specification 17- The GAs are updated by module/course coordinators in the students' study guides 18- Updated study guides are sent to the year leader to be sent to the students 19- QDU ensures wide publication of GAs.
Records	- Approved MBBS program graduates' attributes - Approved matrices: Program GAs-UT GAs, GAs-PLOs
References	- National qualification framework - SAUDI-MEDs framework - CanMeds framework - Guide of programs and study plans at the university - Matrix of authorities

5- Program Learning Outcomes

Determinants	1. The program has program learning outcomes (PLOs) that are SMART and consistent the program mission and goals 2. The PLOs should be consistent with the specifications of LOs for the 7th level in the NQF and with the PLOs of SAUDIMEDs framework and with academic, professional, and health sector requirements. 3. Teaching and learning strategies and assessment methods should encourage active learning 4. Teaching and learning strategies and assessment methods in the program should vary according to its nature and level, enhance the ability to conduct research, and ensure students' acquisition of higher cognitive skills, self-learning skills, clinical/practical skills and values.
Responsibility	Head of Programs and study plans committee
Scope	Program coordinator Members of Faculty council Programs and study plans committee Academic staff members Advisory committee
Inputs	• MBBS program mission, goals and graduates' attributes • The national qualification framework • SAUDI-MEDs framework
Procedures	1- The head of the programs and study plans committee determines the members of the work team (the committee members, head of departments, experts in medical education) 2- The team is approved by the vice dean 3- The head of the programs and study plans committee distributes roles and forms and identify the time frame for completion 4- The team reviews the program mission, goals and graduates' attributes 5- The team reviews the previous PLOs and the notes on them. 6- The team reviews the NQF criteria for level 7, the last updated NCAAA forms and last updated SAUDI-MEDs framework.

	7- The team reviews the PLOS of peer programs, the new development in the medical field and healthcare sector requirements. 8- The team formulates the PLOs aligned with the appropriate teaching strategies and assessment method. 9- The matrices of alignment of PLOs- NQF, PLOs- SAUDIMEDs PLOs and PLOs are prepared by the programs and study plans committee. 10- The PLOs and alignment matrices are presented to and discussed with the faculty council 11- The PLOs are adjusted by the assigned team according to the notes that are received from the faculty council 12- The PLOs are presented to the advisory committee 13- The PLOs are adjusted by the assigned team according to the notes that are received from advisory committee 14- The PLOs are presented to and approved by the faculty council and raised to the UT standing committee of programs and study plans 15- If there are notes, the UT standing committee of programs and study plans write its notes and send them to program coordinator for adjustment. 16- The assigned team makes the required adjustments and the PLOs are re-submitted to the faculty council for approval that re-submits them to the UT standing committee of programs and study plans for final approval. 17- Workshop is conducted for training of the academic staff members to formulate the course learning outcomes (CLOs) in accordance with PLOs.
Records	Approved program learning outcomes Meeting minutes of programs and study plans committee with report on the matrices of alignment Faculty council meeting minutes for approval of PLOs Workshop log
References	Program study plan, mission and goals National qualifications framework SAUDIMEDs Framework Matrix of authorities

6- Program Study Plan

Determinants	1- The program has a detailed study plan showing the courses, their classification, their sequence, the number of accredited hours, their pre/corequisites, the classification of courses; required, elective and university/ college/department requirement 2- The study plan ensures the balance between the general and specialty requirements, and between theoretical and skill aspects; and it takes into account the sequencing and integration of the courses. 3- The program study plan considers the adequate requirements in accordance with international practices and similar programs.
Responsibility	Head of Programs and study plans committee
Scope	Program coordinator Vice dean Programs and study plans committee Advisory committee Academic staff members
Inputs	• Program mission, goals, GAs • Program and course learning outcomes • Reference comparison • The justification of the programs and plans committee for proposed adjustment, modernization or construction. • The national framework for studying qualification
Procedures	1- Head of the program and study plans committee determines the members of the working team with the approval of the vice dean and distributes the roles, models and time frame for carrying out together with justifications for the proposed adjustment, modernization or construction with complete adherence to the following: - Not less than the minimum number of credit hours required for the intended qualification (level 7) - Include courses based on graduates' attributes and learning outcomes - The policies and powers of building, amending and the development of the university's study plan

	- The university's course coding system - Coordinating with the various academic departments 2- Draft the updated / adjusted/ new study plan 3- Submitted to be discussed by the faculty council 4- Adjustment of the received notes from the council 5- Presentation of the plan to the advisory committee 6- Adjustment of the plan according to the notes that received from the advisory committee 7- Presentation of the plan to the faculty council for approval 8- Submitted to the university vice presidency for academic affairs at the university through the electronic system " Bina" 9- Reviewing by the university vice presidency for academic affairs at the university and submitted to external arbitration 10- Adjustment the plan according to the notes contained in the report of the university vice presidency for academic affairs at the university and the external arbitration report for the program 11- Submitting to the university vice presidency for academic affairs at the university to complete the procedures for its approval and send to admission and registration to be installed in the system 12- Announced to students
Records	Approved program study plan Team's meeting minutes Faculty council meeting minutes
References	National qualification framework University program and plan guide Matrix of authority

7- Courses Learning Outcomes, Courses and Field experience Specifications

Determinants	1. The program courses have course learning outcomes (CLOs) that are SMART and consistent the program learning outcomes 2. The CLOs should be consistent with the specifications of LOs for the 7th level in the NQF and with the PLOs of SAUDIMEDs framework and with academic, professional, and health sector requirements. 3. Teaching and learning strategies and assessment methods should be valid and encourage active learning 4. Teaching and learning strategies and assessment methods in the course should vary according to its nature and level, enhance active learning, and ensure students' acquisition of higher cognitive skill, self-learning skills, practical/clinical skills and values 5. The LOs of the field experience (internship and electives) should be aligned with the PLOs; and appropriate strategies for training, assessment, and training venues are identified in order to achieve these outcomes.
Responsibility	The vice dean Head of Programs and study plans committee Head of academic departments Course/ Module coordinators and teams
Scope	Program coordinator Members of Faculty council Programs and study plans unit Academic staff members Advisory committee CMEU
Inputs	• Program learning outcomes • Program study plan • MBBS program mission, goals and graduates' attributes • The national qualification framework • SAUDI-MEDs framework

Procedures	1- Workshops are conducted by CMEU and the assigned team of PLOs formulation for training of the academic staff members to formulate the course learning outcomes (CLOs) and field experience learning outcomes in accordance with PLOs. 2- The C/M coordinator distributes roles and NCAAA forms and identify the time frame for completion 3- The C/M team reviews the program learning outcomes, mission, goals and graduates' attributes 4- The C/M team reviews the previous CLOs and the notes on them. 5- The C/M team reviews the NQF criteria for level 7, the last updated NCAAA forms and last updated SAUDI-MEDs framework. 6- The C/M team reviews the CLOS of peer programs, the new development in the medical field and healthcare sector requirements. 7- The C/M team formulates CLOs and field experience learning outcomes aligned with the PLOs and with the appropriate teaching strategies and assessment methods and included in the course specification 8- The teams complete the course specification and field experience specification form of the NCAAA, or amends or develops it according to the updated forms, with consideration of all procedure inputs 9- Each C/M team submits the updated specification to the programs and study plans committee for reviewing 10- The committee review the specifications and notes received from the committee are adjusted by the C/M team 11- The CLOs , field experience Los and their alignment matrices are presented to the advisory committee 12- The C/M team adjusts makes the adjustment according to the notes that received from the advisory committee 13- The PLOs, CLOs and matrices of alignment of PLOs- CLOs, PLOs- teaching strategies and PLOs – assessment methods are prepared by the programs and study plans committee.

	14- The course specifications, field experience specification and the alignment matrices are submitted to and approved by the faculty council and raised to the UT standing committee of programs and study plans 15- If there are notes, the UT standing committee of programs and study plans write its notes and send them to program coordinator for adjustment. 16- The C/M team makes the required adjustments and the specifications are re-submitted to the faculty council for approval that re-submits them to the UT standing committee of programs and study plans for final approval and installing it in the admission and registration system. 17- The C/M team updates the PLOs, CLOs, teaching strategies, method of assessment in the students' study guides and internship training guide 18- Updated study guides are sent to the year leader to be sent to the students
Records	Approved courses and field experience learning outcomes and specifications Meeting minutes of module/course teams Meeting minutes of programs and study plans committee with report on the matrices of alignment Faculty council meeting minutes for approval of course specifications Updated students study guides and internship guide
References	Program learning outcomes, study plan, mission and goals National qualifications framework SAUDIMEDs Framework Matrix of authorities

8- Program Specification

Determinants	The preparation of the program specification takes into account the participation of all faculty members Adherence to the matrix of authorities of the academic programs
Responsibility	The vice dean Head of Programs and study plans committee Programs and study plans committee
Inputs	• Mission and objectives of the program • PLOs & GAs • The program study plan showing the courses, their classification, their sequence, credit hours, pre/corequisites, the classification (required, elective), (university, college, department) • Course specifications and a detailed plan for each course that includes the general description of the course, the language of instruction, objectives, teaching strategies, assessment methods and learning resources • Internal and external changes • Reports of Stakeholders surveys, APRs, and course reports • Reference comparison • Matrix linking course learning outcomes with PLOs • Procedural guide for studying programs and plans
Procedures	**1.** The programs and study plans committee prepares the specific documents as inputs for this procedures **2.** The head of the programs and study plans committee determines the members of the work team (the committee members, head of departments, experts in medical education) **3.** The team is approved by the vice dean **4.** The assigned team completes the program specification form of the NCAAA, or amends or develops it according to the forms, with consideration of all procedure inputs **5.** The programs and study plans committee presents and discusses it in the faculty council

	6. The notes that received from the council are adjusted by the assigned team **7.** Presenting it to the advisory committee **8.** Adjustment of the notes that received from the advisory committee **9.** The program specification is to and approved by the faculty council and raised to the UT standing committee of programs and study plans **10.** If there are notes, the UT standing committee of programs and study plans write its notes and send them to program coordinator for adjustment. **11.** The assigned team makes the required adjustments and the PLOs are re-submitted to the faculty council for approval that re-submits it to the UT standing committee of programs and study plans for final approval and installing it in the admission and registration system.
Records	Approved program specification Meeting minutes of programs and study plans committee Meeting minutes of advisory committee Meeting minutes of faculty council
References	NCAAA Form for program specification National qualification framework Programs and plans guide in the university Matrix of authorities

9- Course report and its evidences

Determinants	The program should ensure the quality of teaching through: • Verify the effectiveness of the teaching strategies used to achieve the CLOs and take the necessary measures according to the established procedures. • Identifying the administrative difficulties that the academic staff members faced during the course/module. • Standing on the results and estimates of students and studying the variation in the distribution of grades between the different divisions and the factors that affected them, and identifying priorities for improvement. • Verify the extent to which the quality loop is closed at the level of the course by following up on the percentage of completion of the proposed improvement plan for the previous year • Develop an improvement plan appropriate to the recommendations reached, by the end of preparing the course report The academic staff member should: • Abide by what was stated in the course specification • Follow the course improvement plan. • Be committed to measuring the extent to which the CLOs are achieved, according to the blueprint and matrix prepared by the department or C/M team.
Responsibility	Course/module coordinator and team QDU
Inputs	- Course specification - course reports of the previous year - Students' list (e-register) - CES - Item analysis - CLOs blueprint and measurement report - Students' results - Grade distribution - Pre module meeting minutes

	- Peer-Peer review reports - Sample of teaching methods - Exam schedule
Procedures	1- The C/M coordinator distributes the tasks on the C/M team for completion of different sections of the course report - Collection of all needed evidences - Measurement of achievement of CLOs (excel sheet) - Analysis of grade distribution - Analysis of CES - Report on the previous year improvement plan 2- The C/M coordinator prepares the course report on NCAAA form and presents it in the post-module meeting. 3- The C/M team discusses the student's results and the extent to which the CLOs are achieved and determine, the students' and staff feedback and the appropriate improvement plan for the proposed recommendations. 4- The C/M coordinator revises and finalizes the course report and the report is approved in the post-module departmental / module team meeting. 5- The C/M coordinator uploads the course report to its specific folder on the google drive of QDU. 6- The QDU revises the submitted course reports and check their completion and prepares 7- The QDU gives feedback to the course coordinator on the quality of reports 8- The course coordinator amends according to the notes contained in the report, and re-submit s it to the google drive of QDU 9- QDU prepares a collective report on the plan of improvement in the submitted reports. 10- The collective report and all course reports are approved by the program coordinator and raised to the faculty council. 11- The faculty council discusses and approve the collective report in addition to the post module meeting minutes of the departments and the module teams. 12- The approved collective report and the courses reports are submitted to the deanship of development and quality.

	13- The deanship of development and quality revises all the submitted reports and ensure that they fulfill the requirements of program accreditation and then submits them to the higher standing committee of academic accreditation and quality assurance. 14- The higher standing committee of academic accreditation and quality assurance revises the course reports and ensures the fulfillment of the CLOs and send its recommendations to the deanship of development and quality. 15- The deanship of development and quality sends the recommendation to the program coordinator for follow up. 16- The program coordinator sends the recommendations to the concerned departments, module teams, units and committees for execution for execution (according to the matrix of authorities), follow up of implementation of the improvement plan with supporting entity if needed and the results are recorded in the course report of the next academic year.
Records	Approved courses reports Approved collective improvement plans report Post module meeting minutes Faculty council meeting minutes
References	Course report form of NCAAAA Course/Team management guide QDU Checklist for course review

10- Quality Assurance of Assessment Process

Determinants	The program must have an assessment plan which secures the achievement of the program mission. Assessment process must ensure integrity of the exams. The exam blueprint and all content are confidential property of the course/ module coordinator. Item analysis results must be double checked to ensure right decisions regarding alteration of students' scores and make right decisions when modifying students' scores based on the item analysis results
Responsibility	- Course / module coordinator - Course / module exam committee - Exam Evaluation Unit - Time tables and examination Unit
Procedure	✓ The pre-exam assessment process is managed by "Examination Evaluation Unit". Examination Evaluation Unit is responsible for developing the assessment policy and procedures governing construction of exams and items. ✓ Examination Evaluation Unit revise exams regarding the quality of items, the adherence to the policy of questions distribution per domain of learning, and the adherence to the blueprint of the exam ✓ Before the exam, the course coordinator sends the exam blueprint to the different departments sharing in integrated modules. ✓ Each department holds a meeting to select and categorize the items to be included in the exam. ✓ Items are revised against the standard for item writing then each item is aligned with the corresponding CLO and provisionally define the degree of difficulty of each item. ✓ The departments send the questions to the coordinator who collects them and prepare for a meeting one week before the exam with Examination Evaluation Unit. The meeting includes expert in medical education from the unit, the course coordinator, and representatives from module instructors. In this meeting the following are checked for adherence to the blueprint & all CLOs are covered, adherence to standard for item writing, item classification into easy (20%), moderate (60%), and difficult (20%), and exclusion and replacement of flawed items. ✓ For SAQs, OSPE, problem solving essay questions and structured oral exam the model answer is submitted with questions and revised. ✓ For objective structured clinical examination (OSCE) and structured oral examination (SOE), checklist and rubric are used for assessment ✓ Module coordinator is responsible for preparing the final print of the exam and for printing of the exam papers. Module coordinator together with module instructors are responsible for preparation of OSPE, OSCE and SOE stations. The Scheduling & Examination Unit arranges the exam hall and

	nominate the invigilators. The rules and regulations governing the setting of the exam are known to staff members and students. ✓ All MCQ Exams are machine checked, all answers marked by the machine as missing or double answered are manually checked for each student. SAQs, OSPE and PBL questions are revised, and cross-checked by colleagues sharing in teaching this module according to the submitted model answer. OSCE station are assessed by two staff members. Assignments are checked for plagiarism. ✓ Marks are revised and double checked by the module coordinator and a nominated staff member from the Academic Affairs Unit and then signed by the head of the Academic Affairs Unit for basic modules and signed by the head of the department for the clinical modules. ✓ Signed mark sheets are approved by the Vice Dean and the Dean of FMd then submitted to the e-register system. The system automatically determines the grade of the students based on the entered data. ✓ All entered data are checked, revised and approved by the head of the Academic Affairs Unit. The final results are approved by the vice dean and the marks are released to the students and available on their UT student's account. ✓ After the exam, Measurement and Evaluation Unit is responsible for revising the reliability of the exam questions. Item analysis is a report generated by the MCQs correction machine and revised by the Measurement and Evaluation Unit to review item performance and exam reliability for continuous improvement of the assessment process and for giving feedback to the departments . ✓ The post-exam evaluation of items complies with the Examination and Assessment policy of the MBBS program to recommend (keep/ revise/ or exclude) items from the exam bank. Also, Measurement and Evaluation Unit monitors and follows the process of item bank development by different departments and ensure that the items are in compliance with the guidelines for item writing. ✓ Measurement and Evaluation Unit submit exam samples to the UT Measurement and Evaluation Unit for further auditing ✓ Student's marks are reported to the academic advisor in concern for early spotting of students with poor performance for following up the reason and to apply the possible correcting measures such academic support, personal development sessions, as well as psychological support. ✓ A student may, in an academic year, with no more than two courses, file a grievance/complaint to have his/her grades reviewed within two weeks of announcing the course results. ✓ The student fills out the petition form available at the Academic Affairs unit to review his grade for the course and presents the petition form to his academic advisor who will review and write down his recommendation on the form. ✓ After reviewing by the academic advisor, the student submits the petition form to the Vice Dean who will take the necessary decision. If approved by the vice dean, applications are transferred to the head of the academic affairs unit, who forms a committee of three academic staff members to review the student's marks in all required course exams (theoretical, practical, clinical, ...) within a

	period not exceeding one week from the date of receiving the application. The committee prepares a report of what was found on reviewing the student's grades, and the report is presented to the Vice Dean to approve it and issue instructions on it. The student is informed by the Vice Dean with the result of the reviewing committee.
Records	Exam papers and model answers Exam schedules Students' attendance signed by invigilators Item analysis Meeting minutes of exam evaluation unit

11- Measurement of Program learning outcomes

MBBS PLOs are measured annually directly through measuring the achievement of CLOs in the courses in which mastery level (M) is achieved. MBBS PLOs are measured annually indirectly using stakeholder surveys and graduate employability. Other indirect methods include results of national exams as SMLE and progress test.

The CLOs are measured by the course coordinator using an excel sheet designed by the measurement and evaluation unit where each CLO is aligned with its relevant PLO/s and hence the aligned PLO/s can be measured.

Item analysis and degree of difficulty are calculated automatically for all MCQs. The percentage of students who got the correct answer in OSPE, OSCE, SAQs are calculated manually. Each question may target one or more CLOs.

In the excel sheet, each question is aligned with the relevant CLO/s and the difficulty index for the question in the 4 exam forms (Males and females forms A &B) is added to get the average and all averages of all questions aligned with specific PLO are summed up and their average is calculated to get the achievement in this PLO.

For the 3rd domain (Values) overall assessment is gathered from logbooks/reports/ portfolios/checklists

2- Assessment through field training learning outcomes (internship)

- The assessment of interns is through logbooks and an end rotation evaluation form (EREF) filled at the end of each month in the intern training in clinical departments in the hospital.
- Areas of competency in the EREF are aligned with the field training CLOs for the purpose of calculating its achievement. The student performance regarding a specific area in the EREF is rated from 1-10 according to predefined rubric. The CLO achievement is calculated as the average of the students' performance in all linked items to the matched CLO.
- Field training CLOs are aligned with the MBBS PLOs. Accordingly, the PLOs achievement are calculated as the average of linked CLOs of the field training.
- All data analysis was performed using Microsoft® Excel® for Microsoft 365.

Calculation of MBBS program learning outcomes (PLOs):

The achievement of a specific PLO is calculated as the average of the achievement of the linked mastered (M) level CLOs *(Assessment plan of the MBBS PLOs-2020).*

PLOs achievement is presented as percentage and as score of 5.

PLOs achievement benchmarking & data analysis:

The PLO achievement is benchmarked internally with the previous year achievement, and the satisfactory performance and improvement is compared to the stated target benchmark for the year before. All data analysis was performed using Microsoft® Excel® for Microsoft 365.

Indirect and Other Assessment of MBBS program learning outcomes:

1-The indirect measurement of MBBS PLOs achievement is performed through different stakeholder surveys.

2-Results of SMLE and progress test.

3- Skill transcript, by the end of the program is also used to indirectly assess the achievement of PLOs

Data analysis methodology:

All data analysis is performed using Microsoft® Excel® for Microsoft 365. Satisfaction level was presented as weighted mean and scored on a scale of 5.

12.Monitoring Quality of Teaching.

As the university acquires an appropriate space on Google Drive for each faculty member, in addition to providing all information security conditions, the QDU provide C/M coordinators with link specified for his/her course file to upload all required evidences that ensures the quality of teaching and assessment. The electronic cloud for quality work in the program is an easy and practical way to save and archive the quality work in the program on a regular basis. It facilitates access to all documents related to quality files by all members of the program. It also helps to monitor the extent of academic staff members' commitment to the quality requirements of the course.

It aims to clarify the documentation processes in order to help in improvement and sustainability, as it helps to

- Ensure consistent results
- Prevent errors and reduce costs
- Ensure processes are identified and controlled

Procedures

1. All the requirements of the course file are uploaded by the C/M coordinator in the electronic cloud of the QDU
2. The electronic cloud is available to all teaching staff members in the department to view and benefit from it
3. The QDU arranges files according to the requirements (course information, course report files, Students' assessment, Students' sample)
4. Each academic staff member shall raise the requirements according to the distribution of tasks by the coordinator
5. The C/M coordinator is responsible for following up on the completion of the files at the end of the module
6. The QDU prepares a report on the extent to which the requirements are met and submits it to the C/M coordinator to complete the necessary.

	Requirements	The Content	Notes	Timing of Uploading Content for Documentation on the Electronic File	Responsibility
1	**Curriculum Vitae (CV)**	Updated CV	It is updated periodically and uploaded to the teaching staff member's website and handed over to the course coordinator to put it in the teaching staff member's file	The first week of the module	Teaching staff member
2	**Course specification**	Approved course specification according to the NCAAA form	The specification is reviewed periodically only at the level of teaching strategies at the beginning of each module according to the improvement plans in the previous year course report and after approval by the department council - As for other developmental reviews, the existing controls must be adhered to matrix of authorities and the UT procedural guide to programs and study plans	The first week	Course Coordinator

3	**Time table**	Filled out according to the university form	The TT is sent to the staff and students and uploaded on the google drive	The first week of the module	C/M coordinator

Documenting the Students Results					
1	Reveal the results of the course signed by the program coordinator and Vice dean	The transcript is an official document that is downloaded from the academic system portal after monitoring, reviewing, and approving grades	It must contain the signature of the vice dean or the program coordinator	At the end of the module	C/M coordinator
2	Statistical Analysis for Results	The form contains statistical equations and graphs that help analyze test results	The form is unified and its contents can be used to fill out the section specified to the analysis of the grade distribution	At the end of the module	C/M coordinator
Documenting Student Assessment Activities and Methods					
5	Model Answers for exams	A sample test that contains the correct answers	Agreed upon by the C/M team	After release of results	C/M Coordinator

6	Samples of students' tests for each division were distributed according to performance (highest, average and lowest score)	Corrected forms of students' exam for each section distributed according to performance (highest, average and lowest score)	Distributed according to performance, highest and lowest score	After release of exam results to the students	C/M Coordinator
7	Samples of all the students' classroom and extra-curricular work	Corrected forms of all class and extra-curricular work of the module.	Distributed according to the highest and lowest performance	After release of exam results to the students	C/M Coordinator
Documenting the Students' Evaluation of the Quality of the Course					
1	Results of a analysis of CES	The results are downloaded from google form in the form of an excel sheet	The results obtained resulted from sending a The link of the CES is sent by the C/M coordinator to the leader of each section	At the end of the module	C/M coordinator
Other Assessments of the Course Quality.					
1	A Self-Evaluation Form for the Opinion of Teaching Staff Members/ program leaders	Discussed and recorded in the post module team meeting minutes	Include the opinion of the instructors, program leaders in the course report	At the end of the module	C/M coordinator and team

	Requirement for documentation annual quality work at the course level	Content	Notes	Timing of uploading content for documentation on the electronic file	Respons ibility
Course reports					
1	Course Report	Filled according to NCAAA form	All evidences are attached	With the start of the module and finalized by the end of the module	C/M coordina tor/ team
Close the loop of quality report					
1	Course improvement recommendatio n	Course coordinator discusses the proposed improvement plans within sections report in a meeting the course work team	To be presented to for review to be accepted or modified and then submitted to the councils for discussion and approval	End of the module	QDU
2-	Achievement of course improvement plans report	Assembling of course improvement plans included		End of the module	QDU

13.Annual program Report (APR)

Carry out responsibility	QDU and MEU
Follow up responsibility	Vice dean of Q & D
Reference	Sample (report of the program course) prepared by the national council for evaluation and academic approval Procedural guide for quality management system
Determinants	Mission and objectives of program Power matrix
Inputs	• Program specifications • Courses reports • Measurement of PLOs • Stakeholders' surveys • KPIs performance indicators
Procedures	1. The course coordinators submit the finalized approved course reports to the quality and development unit (approved in the post module meeting). 2. The vice deanship of quality and development forms a team and puts and approves the operational plan for writing the annual program report (APR). The operational plan encloses the distribution of tasks, the coordination of meetings, writing and finalization of the APR. The APR summarizes the quality of the program performance and sets the action plans for improvement of the educational process and other processes. 3. The vice dean of quality and development revises and approves the APR and submits it to the program coordinator for approval and submission to the faculty council. 4. The faculty council discuss the APR, approves it and submits it to the deanship of quality and development. 5. The deanship of quality and development revises the APR and ensures its fulfillment for the requirement of program accreditation and submits it to the higher standing committee of academic accreditation and quality assurance.

	6. The higher standing committee of academic accreditation and quality assurance revises the completion of measurement of the PLOs and sends its recommendations to the deanship of quality and development. 7. The deanship of quality and development sends the recommendations to the program coordinator and follows their implementation. 8. The program coordinator sends the recommendations to the concerned entity. 9. The quality and development unit follows the execution of the improvement plans and the percentage of achievement of the improvement plans is reported in the APR of the next year.
Outcomes	Approved annual program report Faculty council minutes

The Role of the QDU in Closing the Quality loop

1. The QDU should ensure the reality of those recommendations and suggestions, their applicability, and their relevance to the evaluation results
2. Follow up the implementation of recommendations and suggestions in practice within the program and submit them to the concerned authorities and follow up their implementation. A questionnaire is also distributed to employers to find out the extent of their satisfaction with the program's outputs, and for graduates to find out the extent of their satisfaction with their educational experience with the program. The responses to these questionnaires can be analyzed to determine the level of graduates and their ability to learn the outcomes of the program from the point of view of employers and graduates after entering the labor market.

14.Six-Year periodic Evaluation of the Quality of the MBBS Program

Determinants	The program conducts a periodic, comprehensive evaluation every 6 years and prepares reports about the overall level of quality, with the identification of points of strength and weakness; plans for improvement; and follows up its implementation.
Purpose	total evaluation for knowledge program the extent of the success of program in graduating distinguished scientific competencies in the field of specialization the appropriateness of educational practices in achieving the strategic direction of the program the modernization, integration, and balance of what is presented in the program's courses in terms of meeting the requirements of the college and university, the basic requirements of the specialization and its academic and professional development, from the point of view of the beneficiaries evaluate the availability of appropriate resources and facilities
Responsibilities	Vice dean of Q & D QDU and AAU
Inputs	• Program mission and goals • National trends according to the requirements of sustainable development in the kingdom • Statistical reports on students' results • Annual program report and courses reports • The results of implementing the operational plan for program at the end of each academic year (of the previous three years) and measuring the extent of deviation from its objectives • Stakeholders' surveys • Academic experts' reviewer
Procedure	1. The vice deanship of Q &D explores successful practices and pioneering experiences inside and outside the university programs in the field of preparing a self-study report for the academic program The vice dean for Q &D forms organizes 4 committees headed and directed by the "Higher Committee for Academic Accreditation" and develops a proposal for an action plan with the approval of the faculty council

	2. The work plan contains all the procedures and requirements for preparing comprehensive evaluation reports (environmental analysis report, self-evaluation scale and self-study report) responsibilities timelines for implementation and required resources are also specified 3. Academic Accreditation Committees are formed to implement the plan with participation of faculty members and according to their academic and administrative experiences and preferences. 4. The proposal of the work plan is discussed, the procedures are approved, and the organizational structure of the committees is discussed within the vice deanship of Q & D 5. The formed committees meet periodically to determine the tasks assigned to them 6. Each committee submit a periodic achievement report to the "Higher committee for academic accreditation", containing the progress in achievement, as well as difficulties and obstacles 7. The "Higher committee for academic accreditation" is responsible for following up the proper implementation of the work plan approved by the faculty council, coordinating meeting, providing the needs of the various committees and overcoming obstacles 8. The "Higher committee for academic accreditation" compiles and arranges the final report of the various comprehensive evaluation reports of the program which stand on the priorities for improvement 9. The report is presented for independent opinion in accordance with the policies and procedures of the university, which sets out strengths and aspects of improvement. 10. The independent opinion is discussed within the academic accreditation committees and recommendations are discussed to respond or reject them with appropriate justifications. 11. Recommendations and improvement plans are presented to faculty council for discussion to take their views 12. The plans are adjusted in light of the comments received 13. The plans are submitted to the faculty council for approval 14. The improvement plans are included in the operational plan for the program t and linked to the objectives In case that the recommendations are substantive (for example , reviewing and developing the strategic direction of the program), the submission process follows the matrix of authorities
Records	Approved evaluation reports – minutes of faculty council. Committees meeting minutes – approved improvement plans and updated operational plan
References	NCAAA forms for SES and SSRP - Procedural guide for university programs and study plans

15.Identifying training needs

Determinants	**1-** The necessary training is provided for the teaching staff on learning and teaching strategies and assessment methods identified in the program and course specifications, along with the effective use of modern and advanced technology; and their use is monitored. **2-** The teaching staff and employee of the program have the appropriate orientation and technical training and support for the effective use of resources and means of learning. **3-** Teaching staff participate in professional and academic development programs in accordance with a plan that meets their needs and contributes to the development of their performance. **4-** The program management is committed to developing and improving professional skills and capabilities of the supportive technical and administrative staff to keep up with modern developments.
Responsibility	Program coordinator Vice deans Head of academic Departments Faculty manager
Inputs	Improvement plans in of courses reports Improvement plans in APR Determined training needs in operational plan for program Improvement plans from faculty staff member evaluation Training needs for members in different units and committees Training needs of academic staff members
Procedures	1- The vice dean of Q & D determines a specific time frame that corresponds to the official date specified in the letters of the higher authorities to determine the training needs of the staff members 2- The head of the CMEU reviews all the training needs contained in the improvement plans and limits them to the training needs report

	3- A survey is distributed on faculty member for needs assessment 4- Each vice dean determines the training needs of the unit/committee members according to the tasks assigned to them 5- The CMEU raises its training needs to the vice dean for Q&D who in turn submits them to deanship of development and quality which is authorised to provide training programs to develop skills after the training programs are officially announced by the dean of development and quality at the university 6- the program coordinator directs and urges all its members to attend when the training programs are opened to all specially members who need performance improvement. 7- If the places are specified, the program coordinator will nominate members according to their tasks or needs to improve performance.
Outcomes	A letter to the deanship for development and quality with various training needs of the faculty staff members
Reference	Controls and standards of training at Tabuk university

16.FMd Building 's safety plan

Determinants	The objective of the Building Safety Plan is to control known and potential safety hazards to all students, staff, workers and visitors in FMd-UT Provides a physical environment-free of hazards to students, faculty, staff, contractors and visitors, and to manage activities proactively through risk assessment to control the risk of injuries. **The goals:** 1. Provides education to all students, faculty, staff, contractors and visitors on the elements of the Building Safety. 2. Ensures safe work practices and conditions. 3. Minimizes the risk of safety-related incidents by proactively monitoring system in place, and making necessary changes through the maintenance committee and safety committee
Responsibility	Faculty building affairs unit and its affiliated committees
Procedure	Hazard Identification will be an on-going process which will be carried-out through the following formal mechanisms: 1. Immediate reporting of hazards by staff to the Safety & Security Unit Manager. 2. Employee suggestions submitted at unit level. 3. Monthly inspections conducted by department safety designee. 4. Scheduled Environmental Rounds conducted semi-annually.
	Faculty Dean: 1. Reviews and approves the Building Safety plan. 2. Reviews reports provided by the Safety and Facility Management Committee, and when necessary and appropriate, direct the allocation of resources.

Safety and Facility Management Committee:

1. Review reports provided by the Quality and Accreditation Unit designee of safety and Risk Management.
2. Report to the Dean on findings, recommendations actions taken and outcomes.
3. Report hazards judged to be serious immediately to the Safety and Facility Management Committee.
4. Train new staff and orient new student on Building Safety Plan elements, workplace hazards, and emergency procedures.
5. Conduct monthly inspections of respective workplaces. If necessary, request support from the Safety and Facility Management Committee.
6. Assign the roles and duties of their staff in the event of fire or disaster as specified within department level fire evacuation plans.

Faculty staff members:

1. Report immediately all unsafe conditions (hazards), injuries, or illnesses, to their safety Officer.
2. Observe and practice all needed safety procedures and the use assigned personal protective equipment.
3. Attend all required fire, hazardous materials, and electrical - related training safety sessions.

Maintenance Supervisor:

1. Reviews Maintenance requests and report to the Safety and Facility Management Committee on findings, recommendations, actions taken, and outcomes.
2. Ensures that the college meets the fire detection system standard and check the accessibility of fire exits.

	Safety Officer: 1. Directs a facility-wide process to collect information on opportunities for improvement, in the environment of care. 2. Ensures that "No Smoking" signs are adequate. 3. Intervenes whenever conditions pose an immediate threat to life or health, or threaten damage to equipment, buildings or the environment. 4. Reports to Safety and Facility Management Committee on findings, recommendations, actions taken, and outcomes. 5. Ensures that the Fire Extinguishers are periodically checked, no physical damage, sufficient pressure, Serviceable, easily visible, and no obstruction. 6. Ensures that needed signs are posted as appropriate throughout the college to identify hazardous, fire exit, restrict cellular phones, floor level, directions, and restricted areas. 7. Inspects the floor for handicapped, bathrooms, and ensures non-slippery floor surfaces and bars. 8. Ensures that the high-risk areas such as laboratory are fully equipped with appropriate safety equipment. 9. Carries out visual inspection of Fire Hose Reels, Cabinets, Hydrants, and Sprinkler system. Makes sure they are checked periodically and no visual damages are noticed. 10. Carries out visual inspection of all fire detection and alarm system, such as smoke/heat detectors, manual break glass points, fire alarm sounders and panels. No visual damages are noticed. 11. Checks Emergency Exit paths clearance. No obstructions on the entire route. Adequate lights and Exit lights are provided and operational. Evacuation Plans, Exit signs, Safety instructions, and assembly point signs are displayed properly throughout college.

	12. Inspects the staircases, ensures adequate lights, safety and floor level signs are posted. No damage to the steps is noted. 13. Ensures proper housekeeping has been done on the floors and surrounding areas. Proper trash container is provided, trash container is provided with color coded bags as per the waste management guidelines. 14. Ensures that the heating appliances are located in a safe location, far from combustible materials. 15. Ensures electrical outlets are adequate and are properly marked 220 / 110 volts. 16. Inspects improper electrical wiring, unauthorized extension cable connections and reports any observation to Risk Management coordinator. 17. Reports extension cord tip off hazard to Safety Officer. **Medical Laboratory Supervisor:** 1. Ensures that Chemicals and other combustible materials are not stored together. 2. Ensures all chemicals are stored in appropriate containers and marked accordingly. 3. Ensures Material Safety Data Sheets (MSDS) for all chemicals stored are available and easily accessible. 4. Ensures that the regulated chemical waste disposal is followed. 5. 5. Ensures that the stores are arranged, segregated and marked properly. 6. Ensures that combustible materials are not stored along with non-combustible materials. 7. Ensures that NO Storing is taking place on the Floor Area. 8. Ensures items are stored on the shelves; racks are 18 inches clearance between the last item and the ceiling, sprinkler heads & lights.

	9. Checks that the floors, walls and ceilings are in good condition. No cracks or holes / penetration presents. 10. Checks the curtains are not creating any fire / life safety hazard.

17.Emergency Evacuation Training

Purpose:	The program has to ensure that all students, faculty staff members of Medicine are trained in internal emergency preparedness and will be thoroughly briefed and rehearsed on procedures to be followed if fire or smoke occur in their work areas.
Procedure	**Frequency:** Prior to conducting a fire drill: A. Coordinate with the faculty Safety Officer that are on schedule and confirm with him/her regarding drill participation. B. The training program should be scheduled in such manner that it will not interfere with or disrupt the normal class activity. **Tasks:** **The trainees:** The students, faculty and staff are all expected to: 1. Attend and practice the fire drills as schedule. 2. Emphasize and do the scenario using RACE procedures. 3. Demonstrate the PASS procedures using the fire simulated equipment. 4. Familiarization on location of all safety equipment, evacuation plan and assembly point. 5. After the drill, complete the fire drill evaluation form.

18. Maintenance

Determinants	The program management should: 1. Ensure that the faculty buildings are maintained to provide a safe and secure environment, and fit for purpose. 2. Ensure that all maintenance activities of the faculty facility base building systems are conducted in a planned manner and are consistent with the university standards. 3. Provide an environment that meets the faculty mission and goals 4. Ensure the faculty obtains a cost effective and a professional maintenance service, to utilize the available funding. 5. Protect facilities asset by providing high-quality maintenance services. 6. Minimize the risk of unexpected major defects that could affect the faculty facilities. 7. Ensure that the faculty buildings complies with relevant legislation, and that all maintenance work is undertaken in a safe manner.
Procedure	1. Maintenance committee will report to the FMd building affairs unit that will approve the maintenance service and monitor the implementation. 2. Faculty staff members should report defects immediately to the Maintenance committee. Staff should not undertake any activity which may increase the damage or disturb the buildings services. <u>Laboratory equipment</u>: • To schedule and perform maintenance procedures • To schedule maintenance procedures during times of slower workflow. • To verify adequate supplies are on board the system, or available to load, prior to initiating a maintenance procedure. • To perform procedures within the daily, weekly, monthly (by staff), and annual maintenance (by the supplier) categories on different shifts or days. • To avoid having these procedures scheduled for the same day, perform some of them early to stagger the schedule.

• The maintenance checklist should complete and signed by lab supervisors or faculty staff members

The faculty:

Includes all activities necessary to operate, maintain, and provide services for all faculty departments, which include buildings, equipment and utilities, to keep them in a good condition. Basic Services includes:

- Repairing.
- Heating.
- Cooling.
- Ventilation.
- Building air conditioning systems.
- Building Heating, Ventilation and Air Conditioning (HVAC) systems are designed to keep room temperature at comfortable levelsIn the case of temperature failure in the building, it should be reported to the CAMS Maintenance Unit.
- Drinking fountains, etc.
- Bathrooms and WC.

Maintenance Supervisor shall:

1. Ensure that routine services including cleaning , pest control, and waste removal are performed properly. The faculty Maintenance Unit and FMd manager work together to develop cleaning specifications for each building that are unique to its operating requirements.
2. Repairing electrical systems, defective lights, etc.
3. Repairing interior and exterior doors, windows, etc.
4. Repairing roofs, walls, floor, etc.
5. Maintaining general classroom furniture
6. Removing solid waste, recycling, and leftover materials (except hazardous waste requiring special disposal)
7. Report problems through Sahl system

INTERNSHIP

1- Requirement to start Internship

Determinants	1. During the final clinical clerkship year (year 6), each medical student must apply for the Internship Program. Students will be presented with several placement tracks based on the order of medical specialties and the hospital for each specialty. The matching process considers the student's preference and his/ her GPA score. Starting of Internship Program is governed by the following rules: 2. . By the end of the final clinical clerkship year (year 6), students must successfully complete graduation requirements with a minimum of a pass mark in all subjects. 3. Students who fail one or more subjects and pass re-sit exams will only be allowed to start the internship program on the formal approval of results. 4. Students who fail the final year (year 6) in one or more subjects and are asked to repeat the year will only be allowed to join the Internship Program on completion of attendance and gaining a pass mark on these subjects a year later. 5. Placements are based on Gregorian Calendar. Our current practice is to start at the beginning of June or July, according to the time of completion. 6. Once placements are officially released, no changes are permitted. Changes will only be allowed in exceptional circumstances. 7. Students are encouraged to spend at least one major placement in the City of Tabuk. 8. Students must attend the Internship Orientation Program. 3.8. Students must hold a Basic life Support certificate and ensure updated immunizations. 3.9. Students will take full responsibility for organizing electives 9. Health To ensure that interns have: ✓ Necessary occupational and work-place safety including Vaccinations and post-exposure management ✓ Guidance and counselling for those facing social and economic challenges

2- Training hospitals

Determinants	INTERN WELFARE These are effective measures taken to ensure that the intern settles in a center as quick as possible, is comfortable and safe during the internship year to facilitate an adequate learning environment. 1. General Hospitals must meet the Saudi Commission for Health Specialties standards for accreditation as a training facility (Scfhs.Org.SA) 2. Hospitals and training centers will be subject to feedback and evaluation on yearly and on a three-yearly basis. 3. Orientation of interns: All internship training centers shall have a structured orientation program which must include: i. Face-to-face meetings with specialists, medical officers and nursing officer in-charge. ii. ii. Orientation within various departments in the center. iii. An overview of internship guidelines. iv. Scope of duties within each rotation. v. Election of interns' representative. 4. Mentors The center shall have a mentorship program. Mentors shall be appointed amongst the specialists in each Department. Each intern shall be assigned a mentor and the ratio of field supervisor: interns is ≤1:5 5. Resource Materials The hospital management shall ensure that the following facilities are in place: i. A resource center/medical library with current journals/reference books ii. Internet connectivity and accessibility

3- Field Supervisor

Determinants	
	Program Field Experience Supervisor: is defined as a faculty member (Professor, Associate and assistant professor). Required to offer support to the Medical Intern on the following aspects: 1. Organize orientation. 2. Organize regular meetings with the interns. 3. Ensure interns give feedback to the hospital. 4. Ensure internship forms & logbooks are filled and sent to the Medical Internship unit on time. 5. Recognize the difficult intern and notify the unit early. 6. Participate in disciplinary procedures of any difficult interns. 7. Chair meeting of field supervisor to assess performance of the intern. 8. Ensure objective and fair assessment of the interns. 9. Ensure interns are assessed immediately after the rotation. 10. assess achievement of learning outcomes and evaluate the quality of field experience. Program field supervisor receive feedback from rotating medical interns on the following aspects: • The range and effectiveness of teaching methods. • The usefulness and effectiveness of teaching and clinical support provided. • The degree of collaboration with the supervisor in planning learning outcomes and program of supervision. • The degree of support in the provision of information on further training opportunities. • The degree of support on addressing performance issues and conflict resolution Field Experience **Supervisor:** is defined as a clinician in the training hospitals who has been responsible for organizing and supervising the training of Medical Interns. **Criteria of selection Field Experience Supervisor:** Have a Doctoral degree or the equivalent in the required specialty, • Respected and reputable with abilities in teamwork and cooperation with the organization, • Have experience in teaching, • Having the preparedness and the skills for complete collaboration with the corresponding teaching staff in the same specialty to achieve the learning outcomes for the undergraduate medical students . • The Dean should approve the selection based on a recommendation from the Department Council and according to the selection presented by the hospital in the Directorate of Health Affairs, Tabuk Region Role of The Field Experience Supervisor: is required to offer support to the Medical Intern on the following aspects : 1.Provide orientation to the practice ensuring that the intern is: • Introduced to all members of staff, and the stage of training and responsibilities of the intern are known to all. • Aware of the location of educational resources. 2. Provide supervision to the medical interns at a level appropriate to their level of training as indicated below: • Medical intern should not take the principal responsibility of individual patient.

	• The clinical supervisor or the designee must be physically present in the workplace at all times whilst the intern is providing clinical care. • If the supervisor is absent from the medical practice, his/her duties should be delegated to a colleague after coordinating with the program supervisor. 3. The Clinical Supervisor will provide professional education and clinical training to interns including ethical issues, career guidance, self-education, etc.

4- Rotation of Interns

Determinants	Interns must abide by the following rules and regulations concerning their rotation
	1. Rotations Interns will first fill the positions available for rotations in the hospitals before being send to affiliated hospitals. No change of your approved intern's schedule. All rotation must start on the 1st day of Gregorian month. No exception is allowed All rotations must be of complete month. Major rotations must be taken in 2 consecutive months, no splitting is allowed. **2.** The internship unit 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 through the Internship unit. Intern can communicate directly if it is being instructed by the Internship unit. 4. Electives must be requested at least 2 to 3 months in advance to have time for approval. 5. 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 be 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. 6. Evaluation: A 360-degree evaluation forms for all rotations will be used. 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 fulfil all criteria that is set by the department in order to get his/her evaluation. 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. The intern must follow-up his/her evaluation with the department secretary however the evaluation must be sent to the internship unit directly from the department. In special

	circumstances in which the department was unable to send the evaluation directly to the internship unit, the intern must bring his/her evaluation personally to the internship unit in stamped and sealed envelope. 7. The interns will not receive his/her certificate unless he/she has completed all requirements. 8. 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 unit.

5- Interns Conduct

Determinants	**Interns are required to maintain a conduct and behavior appropriate for his/her position.** Few guidelines are as below. **1.** Interns 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". **2. Dress code** ✓ Dress should be decent ✓ Clothing must be clean and neatly pressed. ✓ Faded / yellowish, discolored or ripped clothing is not acceptable. ✓ All clothing should be non-see through. ✓ Undergarments must be worn and inconspicuous under uniform or clothing ✓ Identification badges must be worn at all times. **3. Footwear** ✓ Footwear should be clean, appropriate for clothing, protective and fit securely. ✓ Shoes should be non-permeable ✓ Shoes must have a closed toe and closed heel. ✓ Canvas shoes or "crocs" with holes are not permitted in patient care areas. **4.** ***Hair*** ✓ For men, hair must be clean, neatly groomed and controlled. Long hair must be secured away from the face. Extreme styles and colors are not permitted. Fashion head bands or skullcaps are not permitted. ✓ For ladies, must be covered and head scarves shall not interfere with patient care and safety. Scarves shall not be loose for modesty and safety. Bright colors and glittery designs are not acceptable.

	5. Nails, tattoos, henaa ✓ Nails must be short, neat and clean, to avoid irritating patients during clinical examination. ✓ Artificial fingernails are NOT allowed for all staff and students in contact with patients. ✓ Nail polish, tattoos, henaa and decorative designs are prohibited. **6. Jewelry** ✓ Jewelry must be plain and inconspicuous. ✓ Jewelery must not interfere with patient care or safety. ✓ Only one ring or ring set is allowed. ✓ Well- fitting, not loose, wristwatch is permitted. ✓ Facial piercing jewelery is prohibited. **7. Smoking** is not allowed in the hospital and the rest of university compound. **8. Fragrance** is not to be used in the hospital and patient care areas.

6- Roles and Responsibilities of Interns

Determinants	**Interns have duties and responsibilities, which they must attend for successful completion of internship and for certification** ➢ Medical Interns Responsibilities: These include the following: 1. Clerking patients. 2. Participating as a member of a multi-disciplinary team in the provision of medical care to patients. 3. Diagnosing and treating patients under appropriate supervision. 4. Performing relevant investigations. 5. Guiding patients and relatives with regards to diagnosis, treatment and follow-up. 6. Documenting and regularly updating patients' notes. 7. Writing accurate and informative case summaries. 8. Presenting cases concisely, coherently and competently during ward rounds, grand rounds. Participating in continuing professional development activities. 9. Provide safe patient care. 10. Reporting to and consulting with the supervisor. 11. Participating in triaging patients. 12. Performing any other duties assigned by the supervisor. Medical Intern's Rights ➢ Training under the supervision of qualified supervisory staff. 1- Availability of rich training and academic environment. 2- Enjoying leaves as per Faculty of Medicine policy and procedures 3- Awareness of assessment and evaluation in different placements. 4- Any dispute should be brought to the attention of the Medical Internship Unit Supervisor or the Vice Dean for Academic Affairs.

7- Maintenance of Confidentiality

Determinants	**Interns are required to maintain strict confidentiality related to patients and workplace.** 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 the hospital. The intern cannot use confidential information for any purpose that cause harm to hospital. 3. The INTERN may disclose any of the Confidential Information: -To his colleagues, representatives and advisors that have a need to know for the permitted purposes -To a third party where the Provider has consented in writing to such disclosure; and -On the request or requirement of any judicial, legislative, administrative or other governmental body. 4. Confidential Information will not be used, reproduced, transformed, or stored on a computer or device that is accessible to unauthorized persons 5. Upon the expiration or termination of this Agreement, the Intern: -Returns all Confidential Information to hospital and will not retain any copies of this information; -Destroys all memoranda, notes, reports and other work based on or derived from the INTERN's review of the confidential information; and 6. 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 the hospital and take all reasonable steps necessary to retrieve the lost or improperly disclosed Confidential Information.

8- Reporting Unprofessional Behavior of an Intern

Policy	**Training supervisors involved in the intern training shall report any unprofessional behavior to the concerned Department and the Vice Dean of Clinical Affairs.** It is the responsibility of the supervisor to promptly report if an intern exhibits any of the following: ✓ Attitudes suggesting disrespect, abuse or exploitation of a patient. ✓ Failure to interact with patients professionally and ethically. ✓ Unprofessional and or unethical attitudes towards supervisors or colleagues. ✓ Engagement in inappropriate behavior at the hospital premises. ✓ Obstacles to the acquisition of medical and clinical experience. The Head of the Department shall ensure that proper action is taken and that the Vice Dean of Clinical Affairs is informed of the concerns and the corrective actions are taken if any. The Vice Dean of Clinical Affairs reports directly to the Dean about the issue.

9- Leaves and change of rotation or training site

Determinants	**Leaves during Internship:** Based on the Faculty of Medicine and University of Tabuk system of governance Medical Interns are entitled to the following leaves: Annual leave Medical Intern is entitled to a maximum of 15 days annual leave based on the following: Routine annual leave – 15 days Annual leave must be submitted at least 30 days ahead of the requested dates. Medical Intern cannot apply for more than 5 days in the two-month placement. Medical Intern cannot apply for more than 3 days in the one-month placement. Only one continuously annual leave requested is permitted per placement. A leave authorization should be signed and approved by the Field Experience Supervisor and the Medical Internship Unit Supervisor. No Leave Requests will be approved if submitted to the Internship unit after the 25th of the preceding month of the requested dates. Emergency (Urgent) leaves – 5 days This is limited to urgent and justifiable reasons and dealt with on an individual basis, pending approval by Field Experience Supervisors. Medical Interns must not take more than 2 days per placement (should not interfere with on-call duties). Unjustified or excessive urgent leave will be brought to the attention of the Medical Internship Unit Supervisor for subsequent disciplinary action. Sick leave needs to be authenticated by Governmental health units and is subject to scrutiny and approval by the Medical Internship Unit Supervisor. Unused urgent leave can be used as Annual Leave in the last 2 months of the internship year. Eid Holiday - 5 days Medical Interns are entitled to full 5 working days, either during Ramadan or Hajj Eid holiday, as per the hospital calendar. National Day - 1 day 23 September is the Saudi Arabia National Day. Educational Leave – Total: 10 days The Medical Intern is entitled to 2 educational leaves per year, 5 days maximum in one placement. The request should be submitted at least 30 days in advance of the requested dates, along with proof of registration, including payment receipt, a commercial brochure, program,

poster, or advertisement. A copy of a Certificate of Attendance must be submitted to the Medical Internship Unit within one week of returning from the educational leave. Failure to submit the certificate will result in the deduction of the leave days from the annual leave. Maternity- 6 weeks Medical Interns will need to complete missed programs and post on leave completion

Absence from on-call duties will be subjected to the repetition of placement and further disciplinary action.

The Medical Intern is not allowed to take more than 2 types of leaves in the same placement and not more than 7 days in total.

Delay the start of the internship:

The Intern is not allowed to postpone his/her internship year for more than one year from the date of completion of the graduation requirements.

If the delay is for one to two years, the intern must retake the internal medicine and surgery blocks- when they are held - after the approval of the faculty Council.

Changing training period :

The intern has the right to change one training period during the internship year. 2-Submit a letter of apology from the intern to the hospital to be changed, and he must sign the training supervisor at the hospital with approval. 3-Obtaining the approval of the internship Unit Supervisor. 4-The Intern is obligated to find initial acceptance in the alternative training hospital.

It is required that the period between submitting the application and the period to be changed be a minimum of three months.

The internship Unit at the Faculty of Medicine does not bear any responsibility that may result from the request for change.

Signature the intern is fully responsible for the change request and for the delay in graduation or any other consequences Dropout after training

If the intern drops out the training with an acceptable excuse for a period of no more than six months, then that period is compensated at the end of the internship period.

If the intern drops out with an acceptable excuse for more than six months and for a period not exceeding one year, he shall repeat the entire internship period, after the approval of the College Council.

	If the period exceeds one year, it will be applied with the intern for what applies to the **Postponing the start of the internship. Freeze:** Postponement of one rotation is called “Freeze”, it will be approved by MIU and Clinical Affairs Assistant Dean under difficult circumstances

10- Issuance of Internship Certificate

Policy	***Internship Certificate will be issued Requirements:*** 1-Completion of 12 months training under hospital supervision 2-Clearance from the hospital. 3-Submitting copy of graduation certificate and national ID (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, the intern can receive his/her internship certificate before finishing all requirements, which includes: -Document the necessity of having the internship earlier. This document should include a deadline from the body that the intern is applying for. -Consent about the true information's provided and also the commitment of the intern to fulfil all requirements within the expected period. -Intern must have good conduct and not in academic punishment of any kind. -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.

References

1. NCAAA Academic Accreditation Standard 2018
2. NCAAA Academic Accreditation – Self Study Report of the Program
3. NCAAA KPIs 2019
4. NCAAA Program Accreditation Eligibility Requirements 2020
5. NCAAA Course Speciation template 2020
6. NCAAA Field Experience Speciation template 2020
7. NCAAA Annual Program Report template 2020
8. NCAAA Course Report template 2020
9. NCAAA Field Experience Report template 2020
10. National Qualification Framework 2020