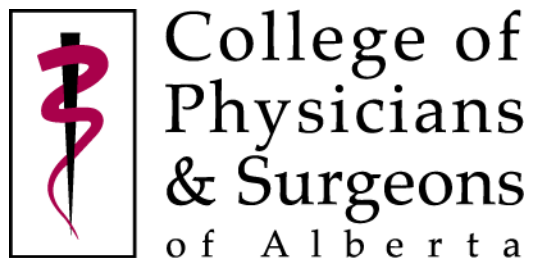


Accreditation Program Guide

Sleep Medicine Diagnostics: New Facilities

Version: May 2018 – v2



Accreditation Program Guide – New/Relocating Facility

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1 Purpose of Accreditation

Accreditation is defined as the public recognition of quality achievement by a healthcare organization, as demonstrated through an independent external peer comparison of the organization's performance against current best practices.

The College of Physicians and Surgeons of Alberta (CPSA) diagnostic accreditation programs:

- assist facilities with a process of ensuring accuracy and reliability of examination/services
- provide standards of practice and assess compliance to these standards
- identify deficiencies that affect the quality of examination/services, and impact patient and/or staff safety
- evaluate a facility's quality system's ability to identify and mitigate risk and variability in system processes
- gives formal recognition that a facility's provision of quality diagnostic services
- encourage and facilitate peer review
- provide educational opportunities for both the facility being accredited and the assessment team
- promote uniformity in practice provincially, where variations in practice are counter-productive for the province
- maintain a comprehensive data repository for scope of service/levels of testing and resources
- promote standardization and educational initiatives across Canada through inter-provincial collaboration
- promote and encourage dialogue amongst stakeholders on best-practices and best ways to incorporate them into the workflow
- ensure effective medical direction over medical practices so that business interests do not determine the standards of care

2 Determination of Requirement for Sleep Medicine Diagnostics Accreditation

Laboratories are required to be accredited by the CPSA's Sleep Medicine Diagnostics accreditation program if they perform and report diagnostic testing for patient management.

3 College of Physicians and Surgeons of Alberta (CPSA) Accreditation Program

3.1 CPSA Lines of Business

The College of Physicians & Surgeons of Alberta is mandated by legislation to regulate the practice of medicine in Alberta and is responsible for licensing physicians, administering standards of practice and conduct, and resolving physician-related complaints.

It also provides leadership and direction on issues of importance to the health care system such as access to services, quality improvement, patient safety and privacy.

The Council of the College of Physicians and Surgeons of Alberta sets direction and policy for the College, while daily operations are managed by the College Registrar and leadership team. College Council includes physician members elected by their medical colleagues and public members appointed by Alberta's Lieutenant-Governor in Council. Alberta's medical school deans also hold a Council seat, and medical learners are represented as observers.

The lines of business for the CPSA are as follows:

- Register physicians
- Investigate and resolve physician-related complaints
- Provide clinical review
- Accredite health facilities
- Guide professional conduct and ethical behavior
- Contribute to public policy affecting health care delivery

3.2 CPSA Mission, Vision and Values

3.2.1 *Our Mission*

Serving the public by guiding the medical profession

3.2.2 *Our Vision*

Albertans are healthier because the College of Physicians & Surgeons of Alberta:

- ensures that physicians are competent throughout their careers;
- supports physicians in providing compassionate, caring and ethical services to the people of Alberta;
- fosters quality health care for all Albertans through innovation, collaboration and cooperation with other key stakeholders; and
- advocates for public policy that contributes to the health of Albertans.

3.2.3 *Our Values*

We do the right thing.

We act responsibly, respectfully and with integrity, aspiring to be fair and responsible. We acknowledge our mistakes as well as our successes, and strive to do what's right in the service to the public.

We make informed decisions.

Our decisions are based on evidence, knowledge, experience and best practice. We plan, measure outcomes and apply what we learn.

We empower people.

We believe people perform best when they see the Vision, set their own goals, have the resources they need to aspire to excellence and personal growth.

We collaborate.

We invite others to contribute to achieving our goals and value their time and expertise. We share what we know generously within our legislated limits, and seek opportunities to collaborate externally in areas of mutual interest.

We are innovators.

We think ahead to create opportunity. We set the bar high and value creativity in exploring new and better ways of doing our work.

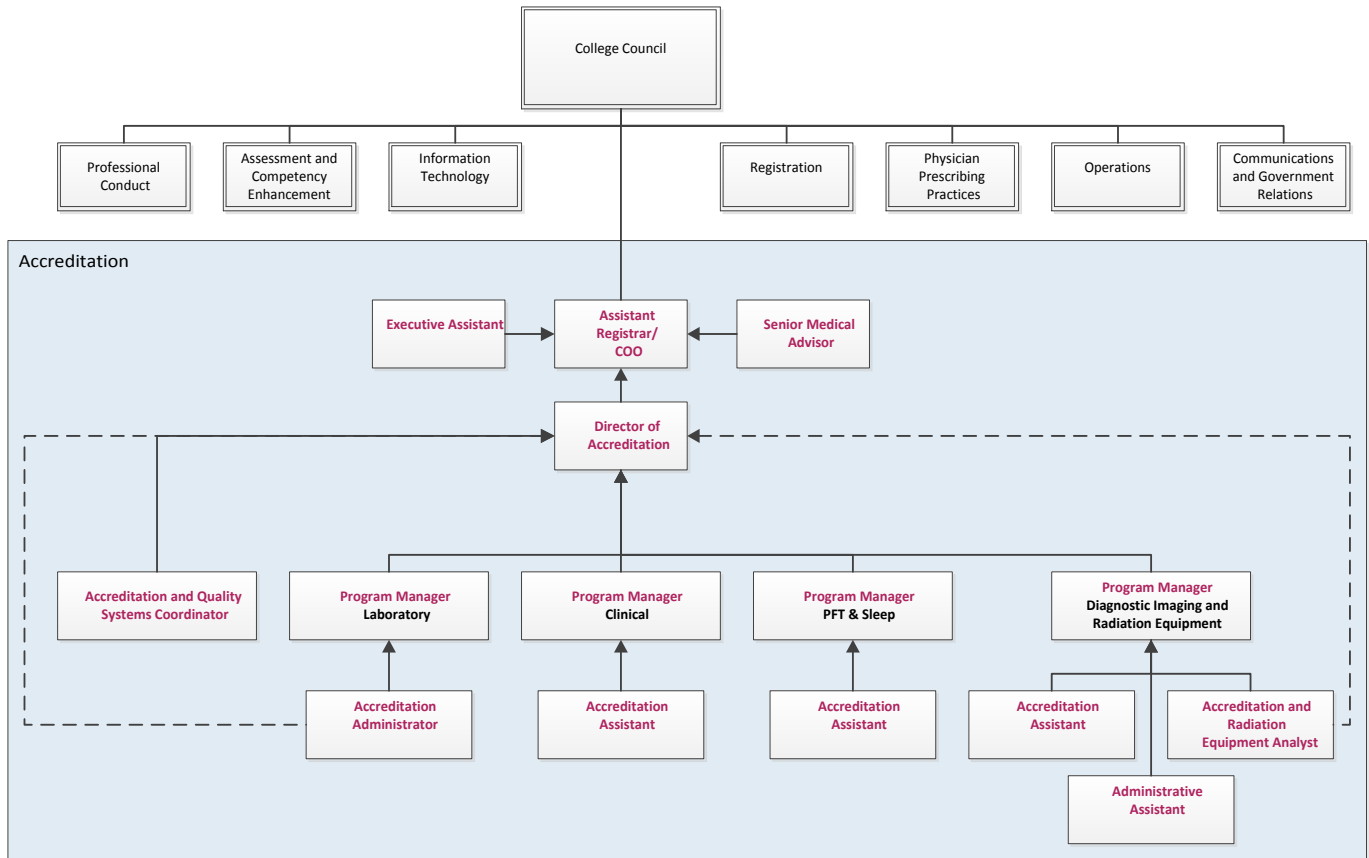
We enjoy and find meaning in our work.

We care about what we do and give our best. While our work is serious, we enjoy camaraderie with our coworkers and take time to celebrate each other's milestones and achievements.

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3.3 CPSA Organizational Structure

CPSA Organizational Chart - Figure 1



3.4 Accreditation Program History

In 1965, the College of Physicians and Surgeons of Alberta, upon recommendation from the Alberta Society of Pathologists, took steps to set up a program for accreditation for diagnostic medical laboratories. The Advisory Committee on Laboratory Medicine, which then reported to Council of the College of Physicians and Surgeons of Alberta, was formed. The mandate of the Committee was to monitor and improve the quality of clinical laboratory services in Alberta. In order to meet this mandate, the Committee developed a process for accreditation that included requirements for on-site assessments of medical laboratories and a proposal for a proficiency-testing program to monitor testing performed.

The first assessments for accreditation took place in 1968 and included only non-hospital-based laboratories. In 1970 the Alberta Department of Health entered into a contract with the CPSA to accredit hospital-based laboratories on their behalf and to make recommendations to them pertaining to accreditation.

The CPSA Accreditation scope has increased since then to include other public and/or private diagnostic programs in Alberta such as:

- Cardiac Exercise Stress Testing (CEST)
- Pulmonary Function Diagnostics (PFD)
- Vestibular Testing
- Hyperbaric Oxygen Therapy (HBOT)
- Sleep Medicine Diagnostics (SMD)
- Non-Hospital Surgical Facilities (NHSF)

3.5 Authority and Oversight

The College of Physicians and Surgeons of Alberta is constituted under the *Health Professions Act* (Schedule 21) with a mandate to regulate medical practitioners and medical practice in the best interests of the public of Alberta. Authority to accredit specified medical services and facilities is one aspect of that mandate.

Pursuant to section 8.4 of Schedule 21 of the Health Professions Act, and the Bylaws of the College, facility staff is required to cooperate fully with any assessment, which shall include:

- a) permitting the assessment team to enter the laboratory facility and assess the premises and all diagnostic equipment located therein;
- b) permitting the assessment team to assess all records pertaining to the provision of Sleep Medicine Diagnostics services, and providing copies of the same if so requested;
- c) providing to the assessment team information requested by them in respect of the provision of Sleep Medicine Diagnostics services in the facility;
- d) providing the information described in clause (c) in the form requested by the assessment team;
- e) providing requested samples or copies of any material, specimen, or product originating from the Sleep Medicine Diagnostics services, provided by the facility;
- f) answering questions posed by the assessment team as to procedures or standards of performance and if requested, providing copies of records relating to procedures followed and standards of performance applied in the Sleep Medicine Diagnostics facility;
- g) providing requested copies of all documents and information relating to business arrangements involving the practice conducted in the Sleep Medicine Diagnostics facility.

Although the CPSA's statutory authority does not extend to health services in approved hospitals or facilities operated by the Government of Canada or the Government of Alberta (Health Professions Act Schedule 21 - 8.1(1)), the value of practice uniformity between the private and public sectors and the credibility of the CPSA's programs have long been acknowledged by practitioners and government. Consequently, four of the CPSA's accreditation programs (Laboratory Medicine, Pulmonary Function Diagnostics, Sleep Medicine Diagnostics and Neurophysiology) are under contract with government agencies to provide accreditation of public sector diagnostic facilities.

The CPSA's accreditation programs are overseen by a standing committee, the Medical Facility Accreditation Committee (MFAC), with members appointed by the Council from diverse disciplines in clinical and diagnostic medicine. MFAC conducts a secondary review of practice standards developed by the accreditation advisory committees, hears argument on all changes to accreditation standards and reviews all facility accreditation and physician approval statuses. A member of the MFAC also attends a full meeting of the individual accreditation advisory committees each year and audits minutes of all other meetings to report on the diligence and objectivity of the work conducted.

The five standing advisory committees are composed of peer professionals (both physician/technical) who identify the needs and realities of Alberta stakeholders based on local practice.

3.6 Overview of Sleep Medicine Diagnostics (SMD) Accreditation Program

The CPSA administers accreditation programs for those services that Council determines deserve explicit standards and verification of compliance with those standards, whether pertaining to the qualifications of physicians who provide them or the safety of those services to the public.

Accreditation looks at compliance, emphasizing continuous quality improvement and promoting optimum performance. More specifically, the CPSA's accreditation program looks closely at policies, processes and procedures to assess the safety and reliability of the service being provided, as well as the performance of the people involved and the product produced.

The Accreditation Program examines all aspects of Sleep Medicine Diagnostics (SMD) testing quality and operations, including:

- organization, management and personnel
- quality management systems including policy, process and procedure
- physical facilities
- equipment, supplies, consumables
- information systems and archival storage
- pre-examination, examination and post-examination activities
- quality assurance activities
- safety
- infection, prevention and control

The SMD Accreditation Program is a peer review process with a goal to improve service provision and performance through objective evaluation. Assessors evaluate facility compliance with the specific requirements of a standard based on objective observation and assessment. All accreditation assessment findings are vetted by the Advisory Committee on Sleep Medicine Diagnostics to eliminate any potential personal assessor bias, ensure a consistent and thorough approach for all facilities, and to review standards for applicability to current best practice.

3.7 Benefits of the CPSA Accreditation Program

- Assists facilities with the process of ensuring accuracy and reliability of testing/services
- Provides standards of practice and assesses compliance to the standards
- Identifies deficiencies that affect the quality of testing/services, as well as patient and staff safety
- Provides educational opportunities for both the facility being accredited and the inspection team
- Promotes uniformity in practice provincially – where variations in practice are counter-productive for the province
- Promotes standardization and educational initiatives across Canada through interprovincial collaboration
- Maintains a comprehensive data repository for scope of service/modalities/levels of testing and resources within the province
- Promotes and ensures dialogue amongst providers and administrators on best practices and best ways to incorporate them into the workflow
- Encourages and facilitates peer review

- Ensures effective medical direction over medical practices so that business interests do not determine the standards of care

3.8 Confidentiality

All assessment findings are confidential and are only disclosed to parties explicitly associated with an assessment. Documented consent must be obtained from the assessed facility for release of assessment findings or accreditation certificates to other parties.

3.9 Frequency and Selection of Laboratories to be Assessed

Sleep Medicine Diagnostic laboratories are assessed initially when opened, subsequently on a four year rotation and if they relocate their laboratory to a different physical facility. This does not preclude an interim assessment that may be required as a result of expansion of services.

At the beginning of the year, all facilities in the area due to be assessed are identified and the Assessment Coordinator is assigned. All facilities performing laboratory examination for patient management are required to undergo an assessment.

After a new facility is registered and initially accredited, it will then be added in to the regular 4-year cycle. If the timing of this next 4-year cycle is very close to when the new facility was accredited, the CPSA may choose not to re-assess the facility.

3.10 On-going Self-Assessment

The CPSA Sleep Medicine Diagnostics Accreditation General Standards requires facilities to conduct formal internal audits of all system elements, both managerial and technical, at a frequency defined in their quality management system. Facilities are not required to submit audit findings to the CPSA.

The CPSA accreditation standard tools are a significant resource for self-audits as they promote a constant state-of-readiness. Laboratories are able to customize the standards tools by:

- tailoring to scope of testing
- documenting/embedding links to policies, processes, procedures, records, forms and labels beside the relevant standard
- utilizing the tool for the performance of comprehensive or targeted audits in between the 4-year CPSA assessments

3.11 Laboratory Classifications

3.11.1 Polysomnography (Level 1)

Labs providing attended sleep diagnostic tests (multi-parametric tests) to assess for sleep disorders which includes the determination of sleep stage.

These labs also provide:

- EEG montages for seizure detection
- Multiple Sleep Latency Tests (MSLT)
- Maintenance of Wakefulness Tests (MWT)
- Esophageal pressure monitoring
- Actigraphy
- End-tidal CO₂ monitoring
- Transcutaneous CO₂ monitoring

Level 1 labs are further classified as providing either services to adult or pediatric patients or both and a distinction is also made between standard or comprehensive polysomnography and polysomnography for complex respiratory patients.

3.11.2 *Unattended Polysomnography Testing (Level 2)*

Lab provides unattended sleep diagnostic tests to assess for sleep disorders which includes the determination of sleep stage.

3.11.3 *Home Sleep Apnea Testing (Level 3)*

A lab providing unattended sleep diagnostic tests to assess for obstructive sleep apnea without the determination of sleep stage. This term aligns with that used by AASM and more clearly aligns with the intent of this testing than any other term. It is otherwise known by many names, including Portable Monitoring (PM) or Level III or LIII or L3 or Ambulatory Testing (AT). At a minimum, devices used in HSAT must record airflow, respiratory effort, and blood oxygenation. The HSAT is **NOT** the same as Unattended Polysomnography Testing (UPSGT).

3.12 Personnel

3.12.1 *CPSA Sleep Medicine Diagnostics Accreditation Personnel and Roles*

The Assistant Registrar, Chief Operating Officer & Hearings Director has overall responsibility for the Sleep Medicine Diagnostics accreditation programs and is supported by the Director of Accreditation, the Program Manager for Sleep Medicine Diagnostics Accreditation and the Accreditation Assistant for the program.

3.12.2 *Advisory Committee on Sleep Medicine Diagnostics (ACSMD)*

The Advisory Committee on Sleep Medicine Diagnostics oversees the CPSA's accreditation program for medical Sleep Medicine Diagnostics facilities; for private facilities as defined in CPSA by-laws and for public facilities through contract with Alberta Health Services. Through the development of evidence based standards and monitoring facility compliance with those standards, the Committee promotes high standards of medical practice in Sleep Medicine Diagnostics facilities.

Roles and Responsibilities of the ACSMD

- Develop and maintain evidence based standards for Sleep Medicine Diagnostics practice;
- Provide advice/recommendations to the Medical Facility Accreditation Committee (MFAC) on pending decisions relating to the provision of Sleep Medicine Diagnostics services;
- Monitor compliance with CPSA approved standards through reviewing on-site assessment accreditation reports;
- Provide education to promote safety and quality improvement initiatives;
- Respond to the needs of stakeholders for improved services in Alberta
- Review and audit of the business practices of the facility to ensure compliance with relevant CPSA by-laws and standards.

Membership and Tenure

Committee members are appointed by MFAC. Membership considers expertise, geographic location, urban versus rural and public versus private representation. Members, who serve by virtue of their position, serve as long as they fill that position.

Membership includes:

- Respiriologists
- Physiologists
- College and Association of Respiratory Therapist representatives

Non-Voting Members:

- CPSA Staff
- Assessment Coordinators

All voting members are registered health professionals responsible to their respective professional regulatory body for their competence, their standards of practice and their conduct.

3.13 Assessment Teams

3.13.1 *Composition*

3.13.1.1 Assessment Coordinator

Each assessment team will include an Assessment Coordinator who is a consultant of the CPSA. During the assessment they look at the facility's policies, processes and procedures and will examine the records and evidence of implementation of the facility's policies, processes and procedures. Sleep Medicine Diagnostics Accreditation is a process-based audit model; it is not possible to directly assess every individual standard for the entire scope of service provision.

While performing assessments for the CPSA, Assessment Coordinators are advised not to display conduct that can be reasonably construed as a solicitation or offer consultant services that may compromise the objectivity of the assessment.

3.13.1.2 Assessment Coordinator Training

All Assessment Coordinators are required to participate in CPSA training sessions before being allowed to perform any on-site assessments. Following completion of the training sessions, they must demonstrate competency by successful completion of an on-line examination.

Upon successful completion of the training sessions and exam, all Assessment Coordinators receive a continuing professional development certificate.

3.13.1.3 Physician Reviewer

A Physician Reviewer will be assigned to an assessment team to perform an examination report/interpretation review.

3.13.2 *Conflict of Interest*

Assessment team members are required to declare any conflicts of interest for each assessment. The names of the assess team are provided to the facility in advance to ensure that the lab has the opportunity to confirm that no conflict of interest exists.

3.13.3 *Confidentiality Agreements*

All members of CPSA committees and accreditation assessment teams sign a Confidentiality agreement with the CPSA on an annual basis. Committee members and Assessment Coordinators are also required to confidentially destroy all assessment materials or return to the CPSA for confidential disposal.

3.13.4 *Liability*

The CPSA's liability insurance specifically extends to cover Assessment Coordinators who are contracted or act as agents. As well, HPA section 126(1) extends liability protection to all CPSA staff, contractors and agents.

4 Standards Document

4.1 Standards Overview

The Standards are the basis for accreditation decisions and are compiled by CPSA and stakeholder experts, they are reviewed and approved by the Advisory Committee on Sleep Medicine Diagnostics, with vetting and approval by the Medical Facility Accreditation Committee, with final vetting and approval by the Council of the College.

The Standards are evidence based and reference accepted best practices, Provincial and Canadian legislation, relevant International Organization for Standardization (ISO) standards, and other recognized provincial, national and international standards. Each accreditation standard has an accompanying reference citation(s).

All standards included in the documents are mandatory requirements for accreditation.

The Standards are process-based and incorporate a quality management system approach. The language, terms and organization of the documents are consistent with ISO 15189, where relevant.

A review of accreditation standards occurs on an ongoing basis considering and incorporating stakeholder feedback. Comprehensive formal review occurs on an annual basis.

All accredited Alberta SMD facilities Medical Directors receive a complete standards document set. CPSA accredited facilities and other approved users may access, print or make a copy of the standards for their non-commercial personal use. Any other reproduction in whole or in part requires written permission from the CPSA and the material must be credited to the CPSA.

Prior to each assessment, standards documents applicable to the scope of the Sleep Medicine Diagnostics services of a facility will be made available to:

- Facilities for self-assessment and/or to prepare for an on-site CPSA assessment.
- CPSA assessors in preparation for on-site assessments and to record objective evidence/observations while performing on-site assessments.

4.2 Format of Standards

The standards are process-based and incorporate a quality management system approach. The language, terms and organization of the documents are consistent (where relevant) with ISO 15189 and ISO 9001 (2015).

The standards document is organized in the following order:

- Leadership
 - Entity
 - Ethics and Conflict of Interest
 - Mission, Vision and Values
 - Goals and Objectives
 - Legislation and Due Diligence
- Planning
 - Quality Management
 - Management of Change
 - Safety
 - Infection Prevention and Control
- Resources
 - Personnel
 - Infrastructure
 - Equipment, Consumables and Supplies
 - Information Systems
- Competence
- Communication and Reporting
- Documented Information
- Operations
 - Pre-examination Policies, Processes and Procedures
 - Examination Policies, Processes and Procedures
 - Post-examination Policies, Processes and Procedures
- Evaluation
- Improvement
- Terms and Definitions
- References
- Appendix: Requirements for Alberta Diagnostic Sleep Medicine Facilities and Services

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Standards Document Format Example - Figure 2

| # | Standard | Reference | Assessment of Compliance |
|---|---|--|--|
| SM.7.1.1 Pre-Examination - Examination Request | | | |
| SM.7.1.1.2 PS | The consultation request form (requisition) includes information sufficient to uniquely identify the patient and the authorized requestor, as well as providing pertinent clinical information necessary for performance and interpretation of the requested examination. | CLSI ⁴ QMS07 – 5.1.1.2 ISO ¹ 15189 – 4.7, 5.4.3 Refer to Appendix A.3 for province specific directives for authorized requestors | <p>Does the consultation request form (requisition) include all of the following elements, if applicable:</p> <ul style="list-style-type: none"> • patient’s first and last name? • a second unique patient identifier (e.g., personal health number)? • date of birth? • gender? • legible full name of authorized requestor? • location/address of requesting physician/healthcare practitioner? • full name, location/address of “copy to” physician/healthcare practitioner? • type of DSM test requested? • any special instructions? • pertinent clinical information including indications, history and provisional diagnosis? • potential contraindications? • indication for a ‘STAT’ report? • date and time of patient referral by requester if applicable? • clinical information where appropriate to the examination requested? <p>If information on the form is incomplete, is there a process for the SMD facility or service to obtain the required information prior to conducting the SMD test?</p> <p>Is there evidence that the facility maintains a written or electronic record of all requests?</p> <p>Are consultation request forms reviewed on a regular basis to ensure they reflect current SMD information and criteria?</p> |
| | | | <p>C <input type="checkbox"/> P <input type="checkbox"/> E <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/></p> |
| | | | <p>Observation:</p> |

Each standard consists of the following components:

Column 1

- CPSA standard number
- Patient or staff safety risk category (where applicable):
 - Each standard has been reviewed to determine if it represents a direct and/or immediate patient or staff safety risk.
 - Those with either a patient safety (PS) or staff safety (SS) designation indicate that any non-compliance may have direct and/or immediate impact on safety.
 - PS/SS standards are ‘shaded’ for ease of detection
 - Assessors must ensure that ALL standards with either a PS or SS designation are directly assessed at the time of the on-site assessment.

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Column 2

- Description of standard requirement

Column 3

- Specific reference(s) linked to reference listing at the end of the document
- Interpretation guidance where relevant regarding the application of requirements

Column 4

- Assessment of compliance questions (AOC) that provide specific guidance and practical direction for evaluation of compliance with the standard
- Compliance assessment category checkboxes
- Observation field for recording of objective evidence (field is expandable in electronic document)

4.2.1 Assessment of Compliance (AOC)

Although the AOC questions address the key evidence required to meet the intent of each standard, they **are not meant to be all encompassing**.

- There may be other evidence that demonstrates compliance with the intent of the standard. Individual assessors apply their own expertise in determining compliance with each standard.
- Compliance with the standard may be assessed by review of documents and records, observation, interviews or a combination of these techniques.
- Where AOCs state “All of the following”, compliance with all elements is expected to achieve compliance with the standard.

| Assessment Compliance Categories: | |
|-----------------------------------|--|
| C | <ul style="list-style-type: none">• meets intent and requirements of standard |
| P | <ul style="list-style-type: none">• in progress (working towards meeting intent and requirements of standard; assessor notes evidence of progress towards full compliance) |
| E | <ul style="list-style-type: none">• exceeds requirements of standard |
| N | <ul style="list-style-type: none">• does not meet intent and/or requirements of standard |

C - “Meets intent” all policies and procedures are in place with accompanying documentation.

P - “In Progress” citations require submission of future evidence of compliance based on direction from the assessor and/or the Advisory Committee. Examples where this assessment may be applied include situations such as: equipment purchased but not on-site and/or implemented; renovations in progress but not completed.

E - “Exceeds Requirement” recognizes those situations where a facility exceeds the intent of the standard and employs commendable practice. The intent of capturing these occurrences is to promote and focus on quality initiatives.

N - “Does not meet intent” upon objective assessment of the evidence, a failure to meet the intent and/or requirement of the standard will result in a citation of non-compliance recorded during the assessment.

The standards are process based and a single non-compliance may encompass one or more observations. In assessing compliance within the standards, assessors objectively record specific evidence of non-compliance in a detailed itemized report.

Receipt of “FULL” accreditation status is contingent upon satisfactory resolution of all non-compliances. This is completed when the CPSA receives evidence from the facility of compliance (N and P).

4.3 Terms and Definitions

A listing of application terms and definitions is provided at the end of each standards document.

4.4 Reference Listing

A detailed reference citation listing is provided at the end of this document. Specific references can be accessed by clicking on individual link(s) included beside each standard. The references support the content and intent of each standard. It should be noted that all components of the cited references may not always be relevant and/or applicable. Compliance is expected with CPSA Standards.

4.5 Review and Revision of Standards

A comprehensive review of references occurs annually to ensure they are compliant with current standard references and best practices. Supporting references are reviewed, updated and their impact (if any) on the wording of the requirement is assessed.

Any stakeholder may offer suggestions for standards revision at any time.

Revision submissions are considered by the CPSA ONLY if they meet the following conditions:

- submitted using the Stakeholder Standards Review Form.
- identification of specific standard or section if applicable to multiple standards
- supported by detailed rationale/justification AND verifiable references (link or attachment must be included)
- applicable to all Sleep Medicine Diagnostics facilities across the province and are not limited to organization specific practice
- contact information included for use by the CPSA if clarification of submission is required

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5 Accreditation Process – New Facility Accreditation

5.1 New Facility – Pre Assessment

| Responsibility | | Task | Additional Information |
|----------------|---------------------------|--|--|
| 1. | Facility/Medical Director | Notifies CPSA of intent to open a new facility | New Facility Registration form completed via the website. The sooner the CPSA is aware of a new facility opening the smoother the accreditation process. |
| 2. | CPSA | Emails the Medical Director a <i>New Facility Application</i> | Directs facility to complete and return |
| 3. | Facility | Completes a New Facility Application | The <i>New Facility Application</i> requests submission of the following for each individual facility undergoing assessment: <ul style="list-style-type: none"> • general facility information • hours of operation • key facility personnel • scope of testing • interpreters • equipment • organizational structure |
| 4. | CPSA | CPSA sets up facility SharePoint site | <ul style="list-style-type: none"> • set up facility SharePoint folder • requests facility SharePoint site access for designated individuals |
| 5. | CPSA | Provides access to SharePoint site for the Medical Director and key facility contact | This allows for the Medical Director and key facility contact to download the accreditation standards |
| 6. | CPSA | Assign Assessment Coordinator and Physician Reviewer | Providing the team access to the SharePoint folder |
| 7. | CPSA | Upload the Assessment Logistics Form (ALF) that includes the name of the proposed assessment coordinator (AC). | Pre-populates the ALF for the site. The facility is requested to complete the form and respond with the Medical Director's signature indicating their approval of the proposed assessment coordinator and physician reviewer. |
| 8. | CPSA | Invoices Registration fee to facility | |
| 9. | Facility | Review Assessment Logistics Form (ALF) and upload to SharePoint | Make any corrections to facility contacts as required. If the assessment coordinator and /or physician reviewer is not approved by the facility due to an identified conflict of interest, the CPSA will solicit alternates and request approval. |

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| Responsibility | | Task | Additional Information |
|----------------|----------------------|---|---|
| 10. | CPSA (AC) & Facility | Determines assessment date in consultation with facility. | <p>Assessment Coordinator communicates with key facility contact identified in the ALF to schedule the onsite assessment.</p> <p>AC provides assessment logistics and details to CPSA.</p> <p>There is a \$500 (plus GST where applicable) fee for any accreditation assessment that is cancelled or requests to be rescheduled, within 30 days of a scheduled assessment date.</p> |
| 11. | CPSA | Sets up AC SharePoint access and uploads documentation | <p>Provides AC with assessment documents to facilitate adequate preparation.</p> <ul style="list-style-type: none"> • New Facility Application • PADV form • Facility policy and procedure manual • Other documents uploaded by facility |
| 12. | CPSA (AC) | Reviews assessment documentation and materials in preparation for the on-site assessment. | <p>The Assessment Coordinator reviews the assessment documentation to prepare to perform a thorough and efficient assessment.</p> <p>The primary purpose is to:</p> <ul style="list-style-type: none"> • become familiar with the scope of activity • identify areas of concern for further follow-up during the assessment |

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5.2 New Facility – On-site assessment (Phase I)

| Responsibility | | Task | Additional Information |
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| 13. | CPSA (AC) | Conduct an opening meeting with facility personnel. | At the beginning of the on-site assessment at each facility, the AC conducts an opening meeting for facility personnel that encompasses: <ul style="list-style-type: none"> • introductions • assessment logistics and timelines • assessment process outline |
| 14. | Facility (facility personnel) | Conducts facility tours for the assessment coordinator. | An initial tour of the entire facility will give a general overview of the facility operation and key personnel. |
| 15. | CPSA (AC) | Conduct on-site assessment. | <p>Assessment Process – General: The accreditation assessment process involves:</p> <ul style="list-style-type: none"> • verifying compliance with the intent of accreditation standards • there may be more than one way to meet the intent of a standard • interaction with staff at all levels <p>AC Behaviour:</p> <ul style="list-style-type: none"> • engage in clear and concise dialogue with facility staff • explain the assessment process to facility staff, as required • assess according to the standards (unbiased approach) • adopt an educational rather than a consultative OR punitive approach • the goal of the assessment is facility improvement does not act as a consultant <p>AC Activities:</p> <ul style="list-style-type: none"> • engage in meaningful dialogue with facility staff (ask open ended questions such as: what, when, where, why, who, how) • compare observed activities to the facility policies, processes and procedures • use techniques, such as: <ul style="list-style-type: none"> – tracer method: follow a sample through pre-examination, examination & post-examination – drill-down: further investigate areas of concern – show/teach me: staff members describe a procedure as they perform it <p>The AC will determine the scope and nature of potential citations by asking:</p> <ul style="list-style-type: none"> • is there a policy, process and/or procedure? • Are the policy, process and/or procedure in compliance with the standards? • Are the policy, process and/or procedure being followed as written? |

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| Responsibility | | Task | Additional Information |
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| | | | <ul style="list-style-type: none"> • Is there evidence of training/competency assessment for the activity? • Is there acceptable documentation of the activity? • Is the required review of the activity performed and documented? <p>If the AC needs any direction/further guidance on the interpretation of a standard or specific cited reference, they are directed to contact the CPSA.</p> <p>The AC will discuss/confirm potential deficiencies with facility representatives.</p> |
| 16. | CPSA (AC) | Records assessment citations | <p>Records the following for each citation in the citation recording template:</p> <ul style="list-style-type: none"> • standard number • compliance assessment category (CPEN) • detailed observation/objective evidence • comments (where applicable) |
| 17. | CPSA (AC) | Notify CPSA immediately of any serious deficiencies that may have immediate impact on staff or patient safety. | <p>AC's encountering any situation that in their judgment, represents potential for significant immediate harm to staff or patients are directed to bring it to the attention of:</p> <ol style="list-style-type: none"> 1) the facility personnel for immediate action as deemed appropriate; 2) The AC will determine the necessity and urgency of contacting the CPSA. |
| 18. | CPSA (AC) | Conduct a summation conference for the facility management and personnel. | <p>The primary purpose of the summation conference is to highlight the key findings, give kudos, and outline the next steps in the assessment process.</p> <p>In person summation conferences are conducted at each facility at the end of the facility assessment.</p> <p>Summation conference agenda:</p> <ul style="list-style-type: none"> • Short review of the objectives of the accreditation process • Review of significant non-conformances (The purpose of this is to ensure that there are no "significant surprises" in the report when received by the facility.) • Overview of the next steps in the CPSA accreditation process including timelines for: <ul style="list-style-type: none"> – meeting of the ACSMD to review the draft final report – distribution of preliminary report – facility responses and submission of EOC – Acknowledgement of facility personnel for their cooperation and support of the accreditation process – Facility questions |

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| Responsibility | Task | Additional Information |
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5.3 New Facility – Post Assessment (Phase I)

| Responsibility | Task | Additional Information |
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| 19. | CPSA (AC) Uploads facility specific report citations to CPSA SharePoint site. | <p>As soon as possible following each facility’s on-site assessment, the AC submits for each facility:</p> <p>Preliminary report citations including:</p> <ul style="list-style-type: none"> • Standard number • Requirement /recommendation • Detailed observation/objective evidence <p>The AC should include any additional information or direction regarding on-site findings that would assist the CPSA in finalizing the requirements and requested evidence of compliance (EOC).</p> |
| 20. | CPSA Formats and finalizes preliminary Phase I facility report. | <p>Based on the preliminary report provided by the AC, the CPSA completes/finalizes the facility report:</p> <ul style="list-style-type: none"> • Facility demographics and key personnel • Assessment information and team details • Accreditation process dates • Facility Overview • Requirements and/or recommendations: • Standard number • Detailed observation/objective evidence • Requirement /recommendation • Evidence of Compliance (where applicable) <p>The CPSA ensures consistent/uniform:</p> <ul style="list-style-type: none"> • application of the standards based on similar observations • wording of requirements and EOC <p>The phase I preliminary report is uploaded to the facility SharePoint site approximately two weeks after the onsite assessment.</p> <p>A response to the report may be provided before the final report is approved by the ACSMD.</p> |

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| 21. | CPSA | Communicates decision on commencement of testing to facility | <p>Based on the communication received from the AC, the CPSA determines whether the facility can commence testing and reporting of patient results.</p> <p>The facility receives an immediate, formal electronic communication indicating:</p> <ul style="list-style-type: none"> approval for commencement of testing (Provisional accreditation status pending ACSMD review) <p>OR</p> <ul style="list-style-type: none"> The requirement for resolution of identified significant non-conformances. Upon resolution of the identified significant non-conformances, the CPSA communicates the approval for commencement of testing and reporting of patient results (Provisional accreditation status pending ACSMD review) |
| 22. | CPSA (ACSMD) | Reviews and approves final facility Phase I report. | <p>ACSMD reviews/revises/ approves the facility assessment report to:</p> <ul style="list-style-type: none"> eliminate any personal bias ensure consistent application of the standards from one assessor/assessment to another endorse EOC requirement ensure standards/requirements reflect current best practice |
| 23. | CPSA | Prepares and distributes final facility report to the Medical Director via SharePoint. | <p>Within 30 business days of the ACSMD meeting, the CPSA:</p> <ul style="list-style-type: none"> formats report to include a section for a facility response to each individual non-conformance/ in-progress citations posts the finalized individual facility report on the CPSA SharePoint site notifies the Laboratory Director of the facility and any designated distribution contacts that the final reports are available |
| 24. | Facility | Submits responses to requirements and requested evidence of compliance. | Facilities must upload their responses and required EOC, where it is requested to the CPSA SharePoint site. |
| 25. | CPSA | Reviews facility responses to requirements and requested evidence of compliance. | <p>The CPSA reviews facility responses to requirements and requested evidence of compliance and provides recommendations to the ACSMD as to the appropriateness of the response.</p> <p>Consults with individual assessment coordinators for clarification where required.</p> |
| 26. | CPSA | Prepares responses for ACSMD review | <ul style="list-style-type: none"> reviews the AC feedback for consistency provides a section in each report to facilitate the Committee responses |
| 27. | CPSA (ACSMD) | Reviews/approves facility responses. | At the next meeting following the receipt of 30 day responses, the ACSMD reviews/revises/ approves the |

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| | | | <p>recommendations of the AC on the facility responses, with a view to:</p> <ul style="list-style-type: none"> • acceptability of response/corrective action • any further action/clarification required |
| 28. | CPSA (ACSMD) | Grants provisional accreditation status pending the Phase II chart review. | |

5.4 New Facility – Study Review (Phase II)

| | Responsibility | Task | Additional Information |
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| 29. | CPSA | Contacts facility regarding study review. | <p>An email is sent to the Medical Director and facility Assessment Contact with a request for patient study submission.</p> <p>Requested will be based on input from AC.</p> <p>The email requests submission of the following for the distant review of patient studies by a Physician Reviewer chosen by the CPSA:</p> <ul style="list-style-type: none"> • policy and procedure manual • 10 complete patient studies including the pre-test documentation/requisitions and letters to the referring physician <p>The facility receives a Phase II report after it is approved by the ACSMD at its next meeting.</p> |
| 30. | Physician Reviewer | Reviews charts and uploads report to SharePoint | |
| 31. | CPSA | Prepares final Phase II report | |

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| Responsibility | | Task | Additional Information |
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| 32. | CPSA (ACSMD) | Vets and approves final facility report. | <p>At the meeting, the reviewer presents the Phase II report to the ACSMD.</p> <p>ACSMD reviews/revises/ approves the facility assessment citations to:</p> <ul style="list-style-type: none"> • eliminate any personal bias • ensure consistent application of the standards from one assessor/assessment to another • endorse EOC requirement • ensure standards/requirements reflect current best practice <p>In addition to providing a report summarizing facility compliance with accreditation standards, the ACSMD also provides an educational service to physicians through feedback with respect to interpretations of the studies reviewed.</p> |
| 33. | Facility | If applicable, the facility submits a response to requirements and/or recommendations requested with evidence of compliance. | <p>Facilities are required to electronically input their response directly into the report and embed any requested supporting documentation/EOC as applicable. Responses are uploaded to the secure facility SharePoint site.</p> <p>For requirements with requests for EOC, facilities must provide a response and any required EOC based on timelines specified in the report (30 days from the date of the report).</p> <p>Responses to requirements without requests for EOC, facilities must provide a response within 30 days from the date of the report.</p> |
| 34. | CPSA | Reviews facility responses to requirements, recommendations and requested evidence of compliance. | <p>The CPSA reviews the facility responses to the requirements, recommendations and requested evidence of compliance and provides recommendations to the ACSMD as to the appropriateness of the response.</p> <p>The CPSA reviews the assessment team feedback for consistency prior to ACSMD review.</p> |
| 35. | CPSA (ACSMD) | Reviews/approves facility responses. | <p>At the next meeting following the receipt of 30 day responses, the ACSMD reviews/revises/ approves the recommendations of the assessment team on the facility responses, regarding:</p> <ul style="list-style-type: none"> • acceptability of response/corrective action • any further action/clarification required |
| 36. | CPSA (ACSMD) | Grants full accreditation status. | <p>Accreditation decisions of the ACSMD are reviewed and approved by MFAC.</p> <p>If a facility is denied accreditation, the facility may access the CPSA formal appeal process.</p> |

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| Responsibility | | Task | Additional Information |
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| 37. | CPSA | Provides accreditation evaluation forms to all relevant stakeholders | <p>To evaluate the effectiveness of the assessment process and customer satisfaction, facilities and the assessment team are asked to provide feedback on the Accreditation Evaluation Survey.</p> <p>Stakeholders are afforded the opportunity for anonymous comment.</p> <p>Results are compiled and reviewed annually by the CPSA.</p> <p>Changes to process are implemented as appropriate based on feedback.</p> |

6 Honoraria and Expense Reimbursement

For assessors - Refer to the current Honoraria and Expense Policy (on the CPSA Assessor SharePoint site) for guidance and information.

7 Assessment Fees for New Facilities

New facilities are invoiced for:

- a Registration Fee which is invoiced upon receipt of the New Facility Registration Form by the CPSA
- an Annual Administration Fee, approximately one week after receipt of the Assessment Report
- a New Facility Assessment Fee which covers the cost of the on-site assessment, approximately one week after receipt of the Assessment Report

Thereafter, an assessment fee will be invoiced following each 4 year on-site assessment.

Payment to the CPSA is due upon receipt of these invoices.

A list of current Sleep Medicine Diagnostics Fees can be found on the CPSA website.

8 List of Accredited Laboratories

A list of CPSA accredited laboratories is available on the CPSA website.