cpsa
COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

Accreditation Program Guide

Pulmonary Function Diagnostics - Management of changes to an accredited facility

JUNE 2020 V3

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1.0 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 & 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 of 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 imaging 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

2.0 College of Physicians & Surgeons of Alberta (CPSA) Accreditation Program

2.1 CPSA LINES OF BUSINESS

CPSA 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.

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The Council of CPSA is composed of physicians elected by members of the profession in Alberta, the two Deans of Medicine in Alberta and four members of the public appointed by the Minister of Health and Wellness.

CPSA regulates the practices of medicine in Alberta including:

- registering physicians
- accrediting health facilities
- supporting continuing competence
- investigating and resolving physician-related complaints
- contributing to public policy affecting health care delivery
- guiding professional conduct and ethical behavior

2.2 CPSA MISSION, VISION, VALUES

Our vision

The highest quality medical care for Albertans through regulatory excellence.

Our mission

Serving the public by guiding the medical profession.

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 and aspire to excellence and personal growth.

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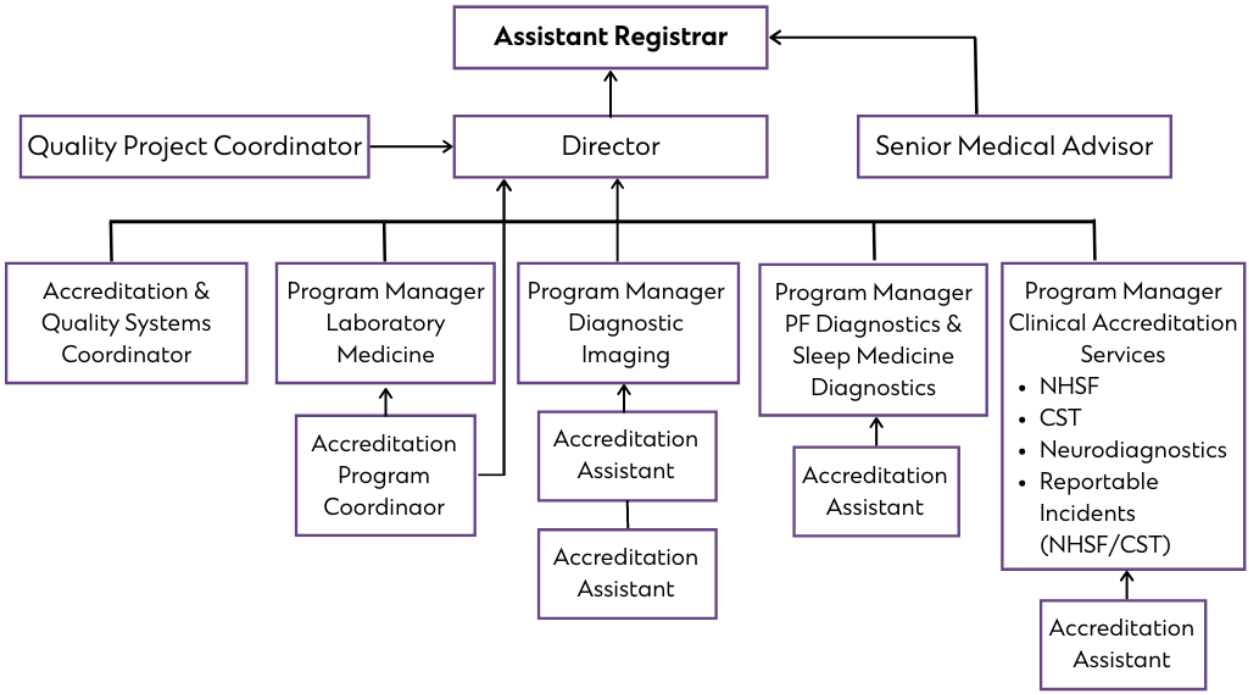
We collaborate.
We invite others to contribute to achieving our goals and value their time and expertise. We share what we know generously within our legislated limits, and seek opportunities to collaborate externally in areas of mutual interest.

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.

2.3 CPSA ORGANIZATIONAL STRUCTURE (ACCREDITATION DEPARTMENT) - FIGURE 1



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2.4 ACCREDITATION PROGRAM HISTORY

In 1965, CPSA, 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 CPSA, 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 CPSA to accredit hospital-based laboratories on their behalf and to make recommendations to them pertaining to accreditation.

CPSA's Accreditation scope includes:

- Diagnostic Imaging (DI)
- Diagnostic Laboratory (LAB)
- Neurodiagnostics (NEURO)
- Cardiac Stress Testing (CST)
- Sleep Medicine Diagnostics (SMD)
- Hyperbaric Oxygen Therapy (HBOT)
- Pulmonary Function Diagnostics (PFD)
- Non-Hospital Surgical Facility (NHSF)

2.5 AUTHORITY AND OVERSIGHT

The College of Physicians & 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 CPSA, facility staff are required to cooperate fully with any assessment, which shall include:

a) permitting the assessment team to enter the 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 Pulmonary Function 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 Pulmonary Function Diagnostics services in the facility;
d) providing the information described in clause (c) in the form requested by the assessment team;

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e) providing requested samples or copies of any material, specimen, or product originating from the Pulmonary Function 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 Pulmonary Function Diagnostics facility;
g) providing requested copies of all documents and information relating to business arrangements involving the practice conducted in the Pulmonary Function Diagnostics facility.

Although CPSA's statutory authority does not extend to health services in approved hospitals or healthcare 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 CPSA's programs have long been acknowledged by practitioners and government. Consequently, four of CPSA's accreditation programs (laboratory medicine, diagnostic imaging, pulmonary function and neurophysiology) are under contract with government agencies (AHS) to provide accreditation of public sector facilities.

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 to report on the diligence and objectivity of the work conducted.

The 6 standing advisory committees are composed of peer professionals (both physician/technical) who identify the needs and realities of Alberta stakeholders based on local practice.

2.6 OVERVIEW OF PULMONARY FUNCTION DIAGNOSTICS (PFD) ACCREDITATION PROGRAM

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, 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 Pulmonary Function Diagnostics (PFD) 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 PFD 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 Pulmonary Function 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.

Benefits of CPSA laboratory 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.

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.

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Frequency and selection of laboratories to be assessed
Pulmonary Function Diagnostic Facilities are assessed initially when opened, subsequently on a four year rotation and if they relocate their facility to a different physical location. 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, with the exception of physicians doing basic testing, 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, CPSA may choose not to re-assess the facility.

On-going self-assessment
CPSA Pulmonary Function 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 CPSA.

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

2.7 LABORATORY CLASSIFICATION

2.7.1 Level II

(Providing a PFT consultation for other physicians)
Tests:
- Vital capacity (VC)
- Timed vital capacity
- Forced expiratory volume in the first second (FEV1) (before and after bronchodilator)
- Forced vital capacity (FVC) (before and after bronchodilator)
- FEV1/FVC (before and after bronchodilator)
- Inspiratory and expiratory flow volume loop (before and after bronchodilator)

2.7.2 Level III

All of the tests included in Level II plus:

- Arterial blood gases
- Co-oximetry
- Oxygen saturation (pulse oximetry) with quantified exercise
- Lung volumes by gas dilution technique or nitrogen washout, or body plethysmography
- Carbon monoxide diffusion capacity
- Non-specific inhalation challenge - methacholine or histamine
- Inspiratory pressure (Pi_{max}) and maximal expiratory pressure (Pe_{max})
- Exercise Broncho provocation

2.7.3 Level IV

All of the tests included in Level II and III plus:

- Advanced cardiopulmonary exercise testing including serial measurements of: oxygen uptake, carbon dioxide production, arterial blood gases (if applicable), and cardiac output during progressive exercise.
- Lung compliance (with esophageal balloon for pleural pressure estimation) and pressure volume curve.
- Chemosensitivity assessment, including ventilatory response to hypercapnia and hypoxia and occlusion pressure (P.1).
- Xenon ventilation and perfusion studies.
- Specific inhalation challenge studies.
- Respiratory muscle assessment including one or more of: transdiaphragmatic pressure (Pdi), respiratory muscle EMG, magnetometer or impedance measurement of chest and abdominal movements.
- Respiratory resistance by oscillation or Mead/Whittenberg technique.
- In subjects under the age of 5 years: assessment of pulmonary function by impulse oscillometry, whole body plethysmography, or rapid thoracic compression.
- Transcutaneous measurements of oxygen and carbon dioxide.

Other tests for pulmonary function may be considered for accreditation upon application.

2.8 PERSONNEL

2.8.1 CPSA pulmonary function diagnostics accreditation personnel and roles

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

2.8.2 Advisory Committee on Pulmonary Function Diagnostics (ACPFD)

The Advisory Committee on Pulmonary Function Diagnostics oversees CPSA's accreditation program for medical Pulmonary Function 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 Pulmonary Function Diagnostics facilities.

Roles and responsibilities of the ACPFD

- Develop and maintain evidence based standards for Pulmonary Function Diagnostics practice;
- Provide advice/recommendations to the Medical Facility Accreditation Committee (MFAC) on pending decisions relating to the provision of Pulmonary Function 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:

- Respirologists
- 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.

2.9 ASSESSMENT TEAMS

2.9.1 Assessment coordinator

Each assessment team will include an Assessment Coordinator who is a consultant of 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. Pulmonary Function 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 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.

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.

2.9.2 Physician reviewer

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

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2.9.3 Conflict of interest / confidentiality agreements / liability

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

Assessment team members are also required to sign a Conflict of Interest Agreement for each assessment cycle to ensure there are no potential conflicts specific to that assessment.

CPSA's liability insurance specifically extends to cover assessors who are employed, contracted or act as agents. As well, the HPA extends liability protection to all CPSA staff, contractors and agents.

While performing assessments for CPSA, assessors 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.

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.

3.0 Standards Document

3.1 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 Pulmonary Function 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.

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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 PFD 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 CPSA and the material must be credited to CPSA.

Prior to each assessment, standards documents applicable to the scope of the Pulmonary Function 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.

3.2 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

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- 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 Pulmonary Function Facilities and Services

Standards Document Format Example - Figure 2

#	Standard	Reference	Assessment of Compliance
PF.7.3	**Examination – Spirometry**		
PF.7.3.2 **PS**	Spirometry examinations are appropriately conducted and reflect current best practice.	ATS[1] – Chapter 6 ATS[2] ATS[4] CPSO[1] – Chapter 19, 20 Ruppel[1] – Chapter 2	Are spirometry examination protocols in compliance with accepted best practice? Are there exclusions criteria for spirometry testing that include, but not limited to, patient with cardiac instability? Does the interpretation for spirometry results include : • reference equations for individual's ≥ 19 years of age, with the lower limit of normal (i.e. lower 5% interval) reported? • prediction equations for individuals < 19 years of age, with the lower limit of normal (i.e. lower 5% interval) reported? • ethnicity correction at the discretion of the medical director and notification on the PFT report if applied as a

			reference set for an individual's spirometry? Do parameters to evaluate spirometry values include at a minimum; • forced vital capacity (FVC)? • forced expiratory volume in the first second to forced vital capacity ratio (FEV_1/FVC)? • peak expiratory flow (PEF)? Is there a procedure for patients on supplemental oxygen?
			C □ P □ E □ N □ N/A □
			Observation:

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.

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)

3.3 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 of Compliance Categories – the CPSA "PEN" or CPEN

Compliance Assessment Category:	
C	meets intent and requirements of standard
P	in progress (working towards meeting intent and requirements of standard; assessor notes evidence of progress towards full compliance)
E	exceeds requirements of standard
N	does not meet intent and/or requirements of standard
N/A	not applicable to scope of service or testing

N - Upon assessment of the objective evidence, failure to meet the intent and/or requirement of the standard will result in an assessment of non-compliance.

The standards are process based and a single non-compliance may encompass one or more observations. In assessing compliance with the standard, assessors will record direct specific objective evidence, which will be included in the report for each non-compliance.

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 complete

Receipt of "FULL" accreditation status is contingent upon satisfactory resolution of all non-compliances (N and P).

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

3.4 TERMS AND DEFINITIONS

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

3.5 REFERENCE LISTING

A detailed reference listing is provided at the end of this document. Specific reference citation details 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.

3.6 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 and any new 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 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

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- supported by detailed rationale/justification AND verifiable references (link or attachment must be included)
- applicable to all diagnostic laboratory facilities across the province and are not limited to organization specific practice
-
- contact information included for use by CPSA if clarification of submission is required

4.0 Accreditation Process – Management of Changes to Accredited Facilities

4.1 ADDED TESTS OR SERVICES

Notification to CPSA is required before a new test or service may be implemented, e.g. the addition of non-specific inhalation challenges, addition of arterial blood gas sampling and analysis, or the changing of the scope of the lab from Level II to Level III.

- The notification must be in writing as soon as possible to facilitate assessment resource planning (Change to Facility form on CPSA's website), sent via email to the Program Manager.
- Notification must occur a minimum of 6 weeks in advance of the planned implementation of the new service.
- Additional information regarding costs and timelines will be provided after notification
- This assessment will be limited to equipment, policies, processes and procedures related to the new service.
- Qualification and site acceptance testing of any associated new equipment will be reviewed on site.
- A review of test reports will be done focused on patients who have undergone the new test.

4.2 CHANGE IN TESTING EQUIPMENT

Notification must be in writing as soon as possible to facilitate assessment resource planning (Change to Facility form on CPSA's ebsite), sent via email to the Program Manager.

On-site assessment at CPSA discretion.

- Factors considered will be:
- Whether equipment is replacement in kind or not
- Changes to procedures as a result of the change in equipment

- Installation qualification / acceptance testing of any new equipment will be reviewed onsite

4.3 RELOCATIONS

Notification must be in writing as soon as possible to facilitate assessment resource planning (Change to Facility form on CPSA's website), sent via email to the Program Manager.

- Additional information regarding costs and timelines will be provided after notification

An onsite assessment will be scheduled:

- An onsite assessment is required before any testing at the new location may occur
- Qualification and site acceptance testing of relocated and any new equipment will be reviewed onsite

- A review of test reports may be done focused on patients who have undergone testing with the new equipment.

4.4 RENOVATIONS

4.4.1 Minor renovations

Notification to CPSA is required in advance of the renovation. An email to the Program Manager with all documents requested below. The determination of whether an on-site assessment is required will be determined based on the information provide to CPSA.

Exceptions to on-site assessment requirement include:

- Reconfiguration of facility spaces without structural changes (this includes moveable wall systems)
- Minor space repairs (e.g. counter top/bench replacement; floor repair, utility changes / upgrades)
- The final determination of whether an on-site assessment is required is at the discretion of CPSA's Advisory Committee on Pulmonary Function Diagnostics
- If it is determined that an onsite assessment is not required, completion and impact of minor renovations will be assessed at the next 4-year accreditation assessment

4.4.2 Major renovations

Major renovations include structural changes to facilities that result in significant changes to physical layout and workflow processes.

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Notification of CPSA is required in advance of the renovation. An email to the Program Manager with all documents requested below, as soon as possible to facilitate assessment resource planning.

- Additional information regarding costs and timelines will be provided after notification

4.4.2.1 Temporary space

If the lab is moving to a temporary space while renovations are occurring the temporary space will be subject to an assessment.

- The assessment will be limited to review of physical space and relevant safety-related standards.
- Qualification and site acceptance testing of relocated equipment will be reviewed on site.

4.4.2.2 Return to current location post-renovation

An on-site assessment is required.

- The assessment will be limited to review of physical space and relevant safety-related standards.
- Qualification and site acceptance testing of relocated equipment will be reviewed on site.

4.4.2.3 Operations continuing during renovation (no temporary facility)

An on-site assessment is required post-renovation.

- The assessment will be limited to review of physical space and relevant safety-related standards.
- Qualification and site acceptance testing of relocated equipment will be reviewed on site.

4.5 AMALGAMATION OF PFD FACILITIES

Notification of CPSA is required in writing as soon as possible to facilitate assessment resource planning (Change to Facility form on CPSA's website), sent via email to the Program Manager.

- Notification must include the effective date of any changes
- Changes to any operations, locations, etc. must be specified,
  - e.g. if a site is being closed, equipment is being moved, specific tests are being consolidated, etc.

On-site assessment at CPSA discretion.

Factors considered will be:

- Changes to procedures as a result of the change
- Consolidation of testing activities
- Moves of equipment between labs
- Staff changes: technical or supervisory staff

4.6 CHANGE IN OWNERSHIP OF PFD LAB

Notification of CPSA is required (Change to Facility form on CPSA's website), sent via email to the Program Manager.

- Notification must be in writing by email to the Program Manager
- Notification must include the effective date of any changes

On-site assessment at CPSA discretion.

Factors considered will be:

- Changes to procedures as a result of the change, e.g. if purchased by a larger lab group that results in adopting new group testing procedures
- Staff changes: technical or supervisory staff

4.7 CHANGE IN MEDICAL DIRECTOR

Notification to CPSA is required (Change to Facility form on CPSA's website), sent via email to the Program Manager.

- Notification must be in writing by email to the Program Manager
- Notification must include the effective date of the change

4.8 CLOSING AN EXISTING ACCREDITED PFD LAB

Notification of CPSA is required (Change to Facility form on CPSA's website), sent via email to the Program Manager.

- Notification must be in writing by email to the Program Manager
- Notification must include the effective date of the closure.

5.0 Honoraria and Expense Reimbursement

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

6.0 Annual/Assessment Fees

Annual Fees
Facilities will be invoiced annually in December for the upcoming fiscal period of April 1 – March 31 for the Annual Admin Fee.

Assessment Fees
An assessment fee will be invoiced on a quarterly basis for facilities assessed in that quarter.