



Accreditation Program Guide

Pulmonary Function Diagnostics - New facility

JUNE 2020 V2

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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 Determination of Requirement for Pulmonary Function Diagnostics Accreditation

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

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

3.1 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.

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

3.2 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.

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.

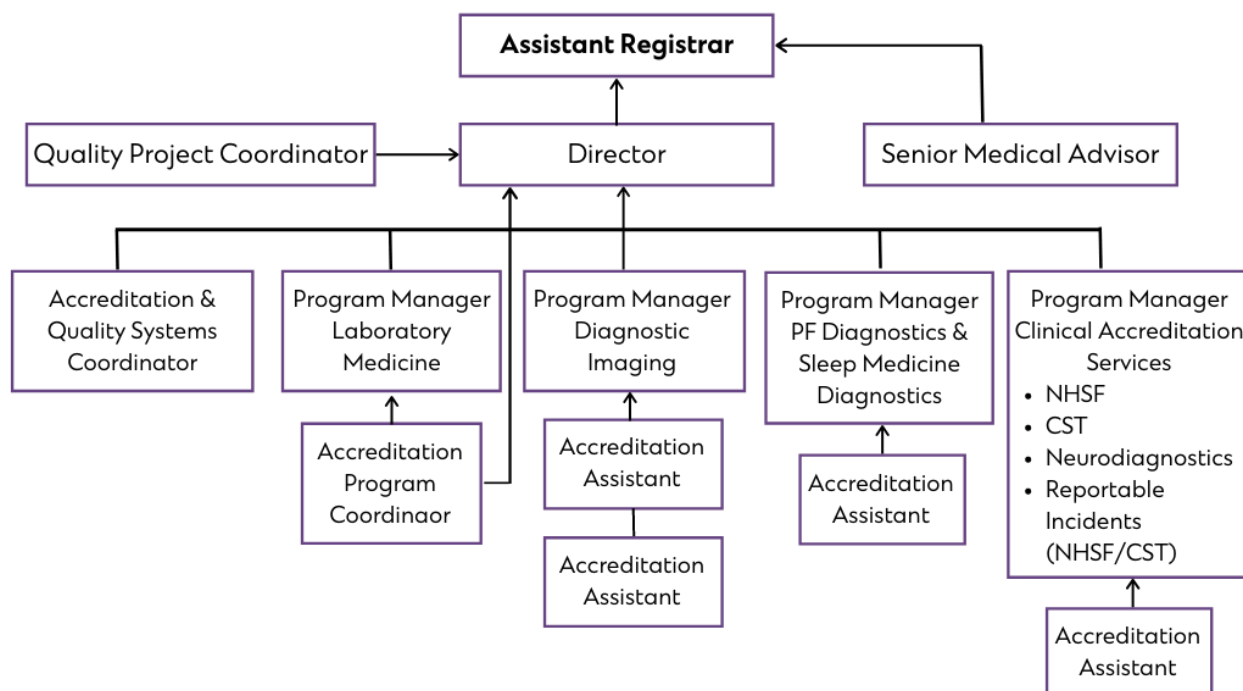
We are innovators.

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.

3.3 CPSA ORGANIZATIONAL STRUCTURE (ACCREDITATION DEPARTMENT) - FIGURE 1



CPSA: June 2020

3.4 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)

3.5 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;
providing the information described in clause (c) in the form requested by the assessment team;
- d) providing requested samples or copies of any material, specimen, or product originating from the Pulmonary Function Diagnostics services, provided by the facility;
- e) 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;
- f) 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.

3.6 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.

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

3.7 LABORATORY CLASSIFICATION

3.7.1 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)

3.7.2 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 ($P_{i_{max}}$) and maximal expiratory pressure ($P_{e_{max}}$)
- Exercise Broncho provocation

3.7.3 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.

3.8 PERSONNEL

3.8.1 CPSA pulmonary function diagnostics accreditation personnel and roles

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.

3.8.2 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.

3.9 ASSESSMENT TEAMS

3.9.1 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.

3.9.2 Physician reviewer

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

3.9.3 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.

4.0 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 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.

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.

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 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 : <ul style="list-style-type: none"> • 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; <ul style="list-style-type: none"> • forced vital capacity (FVC)? • forced expiratory volume in the first second to forced vital capacity ratio (FEV₁/FVC)? • peak expiratory flow (PEF)? Is there a procedure for patients on supplemental oxygen?

			C <input type="checkbox"/> P <input type="checkbox"/> E <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>
			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)

4.3 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 occurrences is to promote and focus on quality initiatives.

4.4 TERMS AND DEFINITIONS

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

4.5 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.

4.6 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
- 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

5.0 Accreditation Process – New Facility

5.1 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 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	Provides facilities with the <i>Pre-Assessment Data Verification (PADV)</i> form via the SharePoint site	

5.1 PRE ASSESSMENT – CONTINUED

	Responsibility	Task	Additional Information
7.	Facility	Complete and uploads the <i>Pre-Assessment Data Verification</i> (PADV) form and other requested documentation to their SharePoint	Required documentation: <ul style="list-style-type: none"> Facility policy and procedure manual Referral forms Copies of staff licenses and certifications
8.	CPSA	Assign Assessment Coordinator and Physician Reviewer	Providing the team access to the SharePoint folder
9.	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.
10.	CPSA	Invoices Registration fee to facility	
11.	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, CPSA will solicit alternates and request approval.
12.	CPSA (AC) & Facility	Determines assessment date in consultation with facility.	Assessment Coordinator communicates with key facility contact identified in the ALF to schedule the onsite assessment. AC provides assessment logistics and details to CPSA. 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.

5.1 PRE ASSESSMENT – CONTINUED

Responsibility		Task	Additional Information
13.	CPSA	Sets up AC SharePoint access and uploads documentation	Provides AC with assessment documents to facilitate adequate preparation. <ul style="list-style-type: none"> • New Facility Application • PADV form • Facility policy and procedure manual • Other documents uploaded by facility
14.	CPSA (AC)	Reviews assessment documentation and materials in preparation for the on-site assessment.	The Assessment Coordinator reviews the assessment documentation to prepare to perform a thorough and efficient assessment. The primary purpose is to: <ul style="list-style-type: none"> • become familiar with the scope of activity • identify areas of concern for further follow-up during the assessment

5.2 NEW FACILITY – ON-SITE ASSESSMENT (PHASE I)

Responsibility		Task	Additional Information
15.	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
16.	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.
17.	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

		<ul style="list-style-type: none"> • 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? • 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 CPSA.</p> <p>The AC will discuss/confirm potential deficiencies with facility representatives.</p>
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5.2 NEW FACILITY – ON-SITE ASSESSMENT (PHASE I) – CONTINUED

Responsibility		Task	Additional Information
18.	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)
19.	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 CPSA.
20.	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 CPSA's accreditation process including timelines for: <ul style="list-style-type: none"> - meeting of the ACPFD 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

5.3 NEW FACILITY – POST ASSESSMENT (PHASE I)

Responsibility		Task	Additional Information
21.	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 CPSA in finalizing the requirements and requested evidence of compliance (EOC).</p>
22.	CPSA	Formats and finalizes preliminary Phase I facility report.	<p>Based on the preliminary report provided by the AC, 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>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 ACPFD.</p>

5.3 NEW FACILITY – POST ASSESSMENT (PHASE I) - CONTINUED

Responsibility		Task	Additional Information
23.	CPSA	Communicates decision on commencement of testing to facility	<p>Based on the communication received from the AC, 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 ACPFD 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, CPSA communicates the approval for commencement of testing and reporting of patient results (Provisional accreditation status pending ACPFD review)
24.	CPSA (ACPFD)	Reviews and approves final facility Phase I report.	<p>ACPFD 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
25.	CPSA	Prepares and distributes final facility report to the Medical Director via SharePoint.	<p>Within 30 business days of the ACPFD meeting, 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 CPSA's SharePoint site notifies the Laboratory Director of the facility and any designated distribution contacts that the final reports are available

5.3 NEW FACILITY – POST ASSESSMENT (PHASE I) – CONTINUED

Responsibility		Task	Additional Information
26.	Facility	Submits responses to requirements and requested evidence of compliance.	Facilities must upload their responses and required EOC, where it is requested to CPSA's SharePoint site.
27.	CPSA	Reviews facility responses to requirements and requested evidence of compliance.	CPSA reviews facility responses to requirements and requested evidence of compliance and provides recommendations to the ACPFD as to the appropriateness of the response. Consults with individual assessment coordinators for clarification where required.
28.	CPSA	Prepares responses for ACPFD review	<ul style="list-style-type: none"> reviews the AC feedback for consistency provides a section in each report to facilitate the Committee responses
29.	CPSA (ACPFD)	Reviews/approves facility responses.	At the next meeting following the receipt of 30 day responses, the ACPFD reviews/ revises/ approves the recommendations of the AC on the facility responses, with a view to: <ul style="list-style-type: none"> acceptability of response/corrective action any further action/clarification required
30.	CPSA (ACPFD)	Grants provisional accreditation status pending the Phase II chart review.	

5.4 NEW FACILITY – STUDY REVIEW (PHASE II)

Responsibility		Task	Additional Information
31.	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 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 ACPFD at its next meeting.</p>
32.	Physician Reviewer	Reviews charts and uploads report to SharePoint	
33.	CPSA	Prepares final Phase II report	
34.	CPSA (ACPF)	Vets and approves final facility report.	<p>At the meeting, the reviewer presents the Phase II report to the ACPFD.</p> <p>ACPF 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 ACPFD also provides an educational service to physicians through feedback with respect to interpretations of the studies reviewed.</p>

5.4 NEW FACILITY – STUDY REVIEW (PHASE II) – CONTINUED

	Responsibility	Task	Additional Information
35.	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>
36.	CPSA	Reviews facility responses to requirements, recommendations and requested evidence of compliance.	<p>CPSA reviews the facility responses to the requirements, recommendations and requested evidence of compliance and provides recommendations to the ACPFD as to the appropriateness of the response.</p> <p>CPSA reviews the assessment team feedback for consistency prior to ACPFD review.</p>
37.	CPSA (ACPF D)	Reviews/approves facility responses.	<p>At the next meeting following the receipt of 30 day responses, the ACPFD 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
38.	CPSA (ACPF D)	Grants full accreditation status.	<p>Accreditation decisions of the ACPFD are reviewed and approved by MFAC.</p> <p>If a facility is denied accreditation, the facility may access CPSA’s formal appeal process.</p>

5.4 NEW FACILITY – STUDY REVIEW (PHASE II) – CONTINUED

Responsibility		Task	Additional Information
39.	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 CPSA.</p> <p>Changes to process are implemented as appropriate based on feedback.</p>

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.