cpsa
COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

Accreditation Program Guide

Sleep Medicine Diagnostics - 4 Year Accreditation

JUNE 2020 V4

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 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

Laboratories are required to be accredited by the CPSAs Sleep Medicine Diagnostics Accreditation Program if they perform and report diagnostic testing for patient management.

2.0 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.

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 Mission

Serving the public by guiding the medical profession.

Our Vision

The highest quality medical care for Albertans through regulatory excellence.

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.

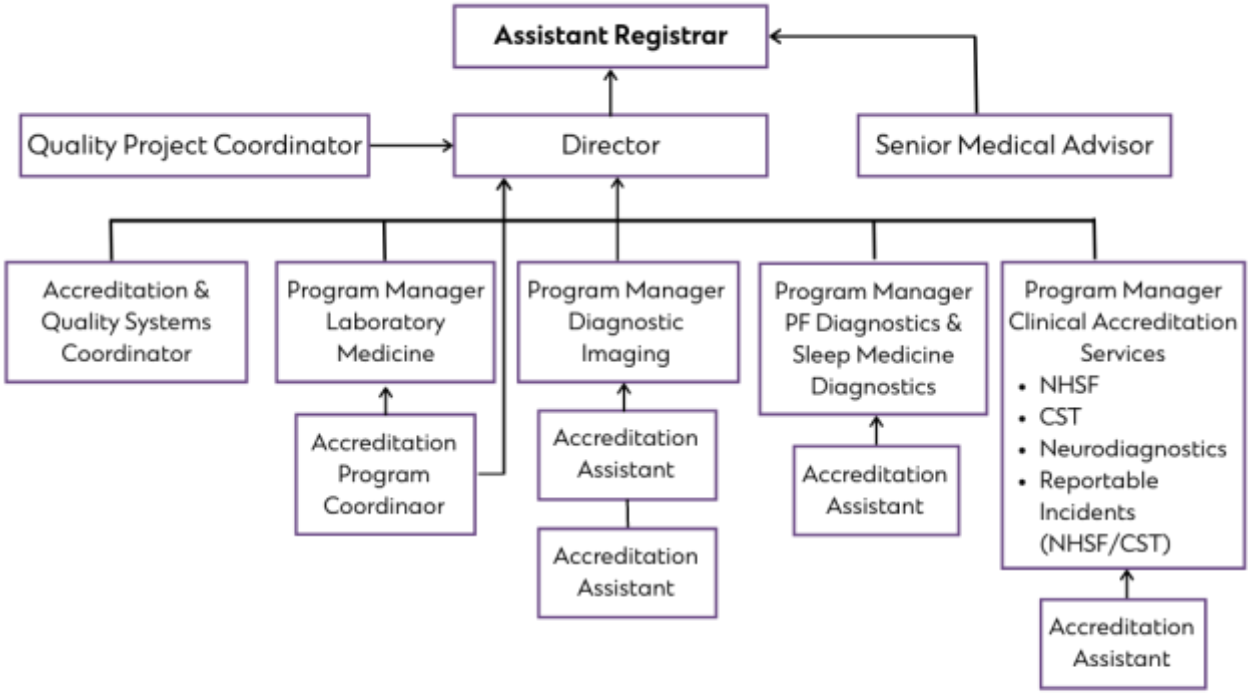
We are innovators.

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.

2.3 CPSA ORGANIZATIONAL STRUCTURE (ACCREDITATION) - FIGURE 1



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 the 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.

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

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

2.5 AUTHORITY AND OVERSIGHT

CPSA 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, SMD 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 sleep medicine testing providing copies of the same if requested;
c) provide the information described in clause (c) in the form requested by the Assessment Team;
d) provide requested samples or copies of any material or product originating from sleep medicine testing for the facility;
e) answer 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 facility;

f) providing requested copies of all documents and information relating to business arrangements involving the practice conducted in the sleep medicine 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 SLEEP MEDICINE DIAGNOSTICS 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 the 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
- 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 sleep testing provision and performance through objective evaluation. Assessors evaluate the facility's compliance with the specific requirements of a standard based on objective observation and assessment.

Benefits of CPSA Sleep Medicine Diagnostic 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 Facilities To Be Assessed

Facilities are assessed initially when opened, subsequently on a four-year rotation or 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 testing services or an unsatisfactory performance complaint.

At the beginning of the year, all facilities due to be assessed are identified by CPSA and the Assessment Team is assigned. All facilities performing diagnostic examinations 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.

On-going Self-Assessment

CPSA accreditation General standards require 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. Facilities 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 assessments

2.7 LABORATORY CLASSIFICATION

2.7.1 Comprehensive Polysomnography (Level 1)

Comprehensive polysomnography is a sleep diagnostic test where the patient comes in and spends the night in a bed hooked to several data gathering systems (EEG [brain wave], EMG [muscle movement], ECG [heart monitoring], OMG [eye movement] etc.) in addition to physiologic parameters, e.g. airflow, respiratory effort, and blood oxygenation level to assess for sleep disorders which includes the determination of sleep stage.

Comprehensive polysomnography labs are further broken down into adult and pediatric labs, and into those that provide other services to the general population and those that also service patients with complex respiratory needs.

2.7.2 Unattended Polysomnography (Level 2)

Unattended polysomnography is a sleep diagnostic test where the patient takes the testing equipment home or is hooked up at a location and then left alone for the night, to assess for sleep disorders which includes the determination of sleep stage via some EEG (brain wave) monitoring in addition to physiologic parameters, e.g. airflow, respiratory effort, and blood oxygenation.

2.7.3 Home Sleep Apnea Testing (Level 3)

Home sleep apnea testing (HSAT) is an unattended sleep diagnostic test to assess for only obstructive sleep apnea without the determination of sleep stage. It is otherwise known by many names, including Portable Monitoring (PM) or Ambulatory Testing (AT). At a minimum, devices used in HAST must record airflow, respiratory effort, and blood oxygenation levels.

2.8 PERSONNEL

2.8.1 CPSA Accreditation Personnel And Roles

The Assistant Registrar, Chief Operating Officer & Hearings Director has overall responsibility for the 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.

2.8.2 Advisory Committee on Sleep Medicine Diagnostics

The Advisory Committee on Sleep Medicine Diagnostics (ACSMD) oversees CPSA's accreditation program for SMD facilities in the community as defined in CPSA by-laws. Through the development of evidence based standards and monitoring facility compliance with those standards the Committee promotes high standards of medical practice in SMD facilities.

Roles and responsibilities of the ACSMD

- Assist with the developing and maintaining evidence based standards for SMD practice;
- Provide advice / recommendations to the Sleep Medicine Accreditation Program

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
- Psychiatrists
- College and Association of Respiratory Therapists of Alberta (CARTA) representative
- Dentists

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.

Sleep Medicine Accreditation is a process-based audit model; it is not possible to directly access 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 before being allowed to perform any on-site assessments.

Following training, new ACs will shadow at least one assessment being performed by an existing AC and be shadowed on one assessment by an existing AC before performing assessments on their own.

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.

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 Assessment Coordinators and Physician Reviewers who are contracted or act as agents. As well, section 126(1) of the *Health Protection Act (HPA)*, extends liability protection to all CPSA staff, contractors and agents.

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.

3.0 Standards Document

3.1 STANDARDS OVERVIEW

The Standards are the basis for accreditation decisions and are compiled by CPSA and stakeholder experts, reviewed and approved by the ACSMD, with vetting and approval by MFAC and final approval by the Council of CPSA.

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 receive a complete standards document set. CPSA accredited testing 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 testing of a SMD 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
- Planning
- Resources
- Competence
- Communication and Reporting
- Documented Information
- Operations
- Evaluation
- Improvement
- Terms and Definitions
- References
- Appendix A: Requirements for Alberta Sleep Medicine Facilities
- Laboratory Classification
- Personnel Qualifications
- Authorized Requestors of sleep testing

Example: Standards Document Format - 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	Does the consultation request form (requisition) include all of the following elements, if applicable: • 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? If information on the form is incomplete, is there a process for the DSM facility or service to obtain the required information prior to conducting the DSM test? Is there evidence that the facility maintains a written or electronic record of all requests? Are consultation request forms reviewed on a regular basis to ensure they reflect current DSM information and criteria? C □ P □ E □ N □ N/A □ Observation:

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

- 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

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.

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

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
- 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 4-Year Re-accreditation

		CPSA	ZONE/SMD FACILITY	ASSSESSMENT COORDINATOR	PHYSICIAN REVIEWER
Initiation	January of Assessment year				
Pre-Assessment	16 weeks prior to assessment	1, 2, 3			
	12-16 weeks prior to assessment	5, 6, 7	4		
	8-12 weeks prior to assessment	11	8, 9	10	
	4-6 weeks prior to assessment			12	12
	2-4 weeks prior to assessment	13			
On-site assessment	Day of assessment		15	14, 16, 18, 19	
Post on-site	ASAP after each SMD facility on-site assessment			20	21
	30/90 days past report distribution		25		
	Review facility responses to requirements, recommendations and requested evidence of compliance.	26		26	
	Next MFAC meeting post response receipt.	28			
	Year end	29			

Note: Time frames are approximations and may vary depending on the scope, scheduling of the individual assessments, and unforeseen circumstances such as facility renovations, or staff resource issues.

4.1 INITIATION

	Responsibility	Task	Additional Information
1	CPSA 16w prior to assessment	• identifies facilities to be assessed • notifies facility Medical Director(s)	• All 4 year facilities revert to provisional accreditation status throughout the accreditation process • Facilities are given their specific assessment initiation timelines at the beginning of the assessment calendar year
2	CPSA	Selects Assessment team members	Selection of the Assessment Team is based on: • scope and complexity of testing services being assessed • experience of Team members mitigation – conflict of interest (employment / affiliation)
3	CPSA	Contact is made to the Medical Director	*INITIAL COMMUNICATIONS* – the Assessment Logistics Form (ALF) is sent directly to the Medical Director. The form asks them to identify a key assessment facility contact.
4	Facility 12-16w prior to assessment	Completes ALF Form	Completed form is submitted with signatures to CPSA within the specific timeline.
5	CPSA 12-16w prior to assessment	Provides SharePoint access	CPSA sets up secure SharePoint access to the CPSA SharePoint site for the key facility contacts identified in the ALF and communicates this information.
6	CPSA 12-16w prior to assessment	Distributes relevant assessment tools (standard documents) to facilities	There may be individual sections and standards within sections that are not applicable to each facility. Assessors will not be assessing these specific requirements.

4.2 PRE-ASSESSMENT

	Responsibility	Task	Additional Information
7	CPSA	SMD facility personnel	Once key facility contacts are identified through the completed ALF, CPSA and the assessment team will then liaise directly with the primary identified accreditation contacts for: • team approvals • pre assessment data verification • on-site logistics • report acquisition and dissemination as appropriate • report responses • submission of responses to CPSA in the designated timeframe CPSA provides the following information: • program guide to review • SMD Accreditation Standards • overview of assessment process steps • direction on the use of the Standards • assessment logistics & timelines • Guidelines for Assessment Contacts SMD facility training sessions are made available on the SharePoint and focus on: • overview of assessment process steps • use of the standards tool • assessment day expectations • assessment logistics & timelines
8	CPSA 12-16w prior to assessment	Provides each SMD facility to be assessed with a "*Pre-assessment Data Verification*" (PADV) Form	CPSA initially pre-populates the form with the most current information within the CPSA database and facilities are directed to carefully review the pre-populated data prior to resubmission to CPSA. The PADV requests submission of the following for each individual facility undergoing assessment: • general facility information • hours of operation • key facility personnel (including those that CPSA will interview via teleconference 1 week prior to the assessment) • scope of modalities (services) • organizational structure • blank examples of facility examination request (requisitions/consultation) forms, consent forms and blank screening form/questionnaires)

4.2 PRE-ASSESSMENT - continued

	Responsibility	Task	Additional Information
9	Facility 8-12w before assessment	Completes PADV Form and uploads to CPSA SMD SharePoint site with required signature within the specified time	CPSA reviews the PADV form for completeness. CPSA follows up directly with the facility contact regarding any missing documentation or documentation requiring additional clarification in the PADV.
10		Advises Medical Director of proposed Assessment Team members and requests formal written approval using the Proposed Team Member Form	The facility Medical Director receives a listing of the proposed Team members including their: • name location of employment/employer scope of assessment activities
11	Facility 8-12w prior to assessment	Uploads assessment materials to SharePoint site	All materials required to complete the pre-assessment are uploaded for the AC to review.
12	CPSA	Reviews submitted forms and prepares assessment documentation	• accesses completed forms and submitted documentation (embedded and uploaded on SharePoint) • AA downloads all desk audit documents submitted via SharePoint into the CPSA facility folders / directories • AA follows up directly with the facility regarding any missing documentation or documents requiring further clarification • reviews organizational chart and management structure and authority of any irregularities • PM conducts high level review of submitted documents to assist team with areas of focus; prepares summary

4.2 PRE-ASSESSMENT – continued

	Responsibility	Task	Additional Information
13	AC 8-12w prior to assessment	Determines assessment date in consultation with the facility	Assessments are not scheduled until all assessment documentation is received. CPSA sets up assessment team access to SharePoint and sends notification. AC notifies CPSA of the assessment date.
14	CPSA	Sends confirmation of team approval and assessment dates to AC and facility	
15	Assessment team 2-4w prior to assessment	Reviews assessment documentation and materials in preparation for the on-site assessment.	Each assessment team member is expected to review the assessment documentation to ensure that they are adequately prepared to perform a thorough and efficient assessment. The primary purpose is to: • become familiar with the standards • become familiar with the scope of service including which programs/processes are zone managed identify areas of concern for further follow-up during the assessment (previous citations)
16	CPSA 1-2w prior to assessment	Conducts internal PFD and external stakeholder surveys	CPSA sends a link to internal / external client stakeholders to complete a brief on-line survey regarding the PFD service. The surveys encompass stakeholder satisfaction with: • physical facility • services • general on-site services including test menu and turn-around time • referral testing services • communication • workload • training and competency Survey findings are reviewed by CPSA staff. Any significant findings are summarized and provided to the assessment team for corroboration.

4.3 ON-SITE ASSESSMENT

	Responsibility	Task	Additional Information
17.	AC	Assessor daily self-assessment	AC completes the daily COVID self-assessment without incident • if an illness is noted, AC contacts PM immediately and follows designated protocols CPSA-AA checks daily to ensure that all ACs have completed survey and let PMs know if they have not
18.	AC On-site	Conduct an opening meeting with zone/facility personnel	At the beginning of the on-site assessment at each facility, the AC conducts an opening meeting for zone/group/facility personnel that encompasses: • introductions • assessment logistics and timelines • assessment process outline
19.	PFD facility	Conducts facility tours for assessment team members	An initial tour of the entire facility will give a general overview of the operation and key personnel.
20.	AC On-site	Conduct on-site assessments	**CPSA Assessment Tool:** The on-site assessment is performed using the facility specific standards document tools. Each assessor must utilize the Standards as a tool. **Assessment of Compliance** • 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 standard. Where AOCs state "all of the following", compliance with all elements is expected (e.g. test request form) 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.

4.3 ON-SITE ASSESSMENT – continued

	Responsibility	Task	Additional Information
21	AC On-site	(cont'd)	Guidance for Assessors When assessing facility sections: It is not possible to review the entire scope of operations • focus on areas of highest and lowest pulmonary function diagnostics volumes, likely problem areas and pulmonary function diagnostics results with highest impact on patient care • directly assess ALL standards with either a PS or SS designation • verify that all non-conformances cited on the previous assessment have been corrected • utilize CPSA Assessor Guides to focus/direct assessment • Review Zone managed programs/processes • Review documents (policies, processes and procedures - PPPs) and records • the assessor should choose a random, representative selection of documents, records and reports to review • assessors should not rely solely on documents, records and reports chosen or selected by the facility for review Observe activities: • engage in meaningful dialogue with facility clinical and non-clinical 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: • 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 Gather information: • always seek corroboration/validation/verification of findings • evaluate for significance

4.3 ON-SITE ASSESSMENT – continued

	Responsibility	Task	Additional Information
21	AC On-site	(cont'd)	Compliance Assessment Categories: Non-conformances (N) • failure to meet the intent and/or requirement of the standard The standards are process based and a single non-compliance may encompass one or more observations. In-progress citations (P) • working towards meeting intent and requirements of standard; assessor notes evidence of timely progress towards full compliance • 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 • are not meant to address partial or incomplete compliance (e.g. incomplete manuals) Exceeds requirement citations (E) • recognize those situations where a PFD 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
22	AC On-site	Notify AC/CPSA immediately of any serious deficiencies that may have immediate impact on staff or patient safety	Assessors 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: #1 - the pulmonary function diagnostics personnel for immediate action as deemed appropriate #2 - AC who will consult with CPSA immediately via telephone

4.3 ON-SITE ASSESSMENT – continued

	Responsibility	Task	Additional Information

23	AC
	On-site
		Conduct a summation conference for the PFD facility management and personnel	The primary purpose of the summation conference is to highlight the key findings and outline the next steps in the assessment process.
			The AC serves as the primary spokespersons during the summation meeting in order to bring consistency of format and detail to the process.
			In person summation conferences are conducted at each facility at the end of the facility assessment.
			Summation conference agenda:
			• Short review of the objectives of the accreditation process
			• Review of commendable findings and practices including any 'E' citations
			• 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/zone.)
			• Review of purpose and inclusion of interview findings in final reports
			• Overview of the next steps in CPSA accreditation process including timelines for:
			  ○ meeting of the ACPFD to review the draft final report
			  ○ distribution of final report
			  ○ PFD facility responses and submission of EOC
			• Acknowledgement of PFD facility personnel for their cooperation and support of the accreditation process.
			• facility questions

4.3 ON-SITE ASSESSMENT – continued

	Responsibility	Task	Additional Information
24	AC	Request sampling of interpreted reports for independent review	A random sampling of 10 charts from the previous three months of testing done at the facility should be requested. The charts should represent the case mix of the population served by the lab. Preference is for secured electronic submission of associated reports/paperwork, etc. The PFD facility will be asked to upload the chosen examinations into the electronic portal. Same day upload is optimal. The PFD facility will have 5 business days from the date of the on-site assessment to provide the documentation. The PFD facility will notify CPSA when the reports are ready for review. Examinations and associated reports/paperwork that can be taken away by the AC on the same day.
25	AC	Uploads findings to SharePoint in a citation report	Within 7 days following the assessment the AC will upload their audit findings along with any photographs, sample documents, etc. to the SharePoint site.

4.4 POST ASSESSMENT

	Responsibility	Task	Additional Information
26	CPSA (Physician reviewer)	Physician reviewer reviews reports to ensure ATS criteria for interpretation are being met	The PR will have one business week to review the reports and associated paperwork and submit findings back to CPSA via SharePoint.
27	CPSA	Reviews physician reports	If required citations are added to the assessment report if necessary from the review of the chart report.
28	CPSA	Vets and approves assessment facility report	Reviews/revises/ approves the facility assessment citations to: • 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 In addition to providing a report summarizing facility compliance with accreditation standards, CPSA also provides an educational service to physicians through feedback with respect to interpretations of the studies reviewed.
29	CPSA	Loads the assessment report into the facility's folder on SharePoint, notifies the facility the report is available	
30	Facility	If applicable, the facility submits a response to requirements and/or recommendations requested with evidence of compliance.	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. For requirements with requests for EOC, facilities must provide a response and any required EOC based on timelines specified in the report (30 or 90 days from the date of the report). Responses to requirements without requests for EOC, facilities must provide a response within 90 days from the date of the report.

4.4 POST ASSESSMENT - continued

	Responsibility	Task	Additional Information
28	CPSA	Reviews facility responses to requirements, recommendations and requested evidence of compliance.	CPSA reviews the facility responses to the requirements, recommendations and requested evidence of compliance and provides recommendations to MFACP as to the appropriateness of the response. CPSA reviews the assessment team feedback for consistency prior to MFAC review.
29	CPSA (MFAC)	Grants full accreditation status.	Accreditation decisions are reviewed and approved by MFAC. If a facility is denied accreditation, the facility may access CPSA formal appeal process.
30	CPSA	Provides accreditation evaluation forms to facilities	To evaluate the effectiveness of the assessment process and customer satisfaction, facilities are asked to provide feedback on the Accreditation Evaluation Forms. Stakeholders are afforded the opportunity for anonymous comment. Results are compiled and reviewed annually by the CPSA. Changes to process are implemented as appropriate based on feedback.

5.0 Honoraria and Expense Reimbursement

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

6.0 Fees

6.1 ANNUAL FEES

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

6.2 ASSESSMENT FEES

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