Accreditation Program Guide

Sleep Medicine Diagnostics - New Facility

November 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 practise 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, VISSION & 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 is right in 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.

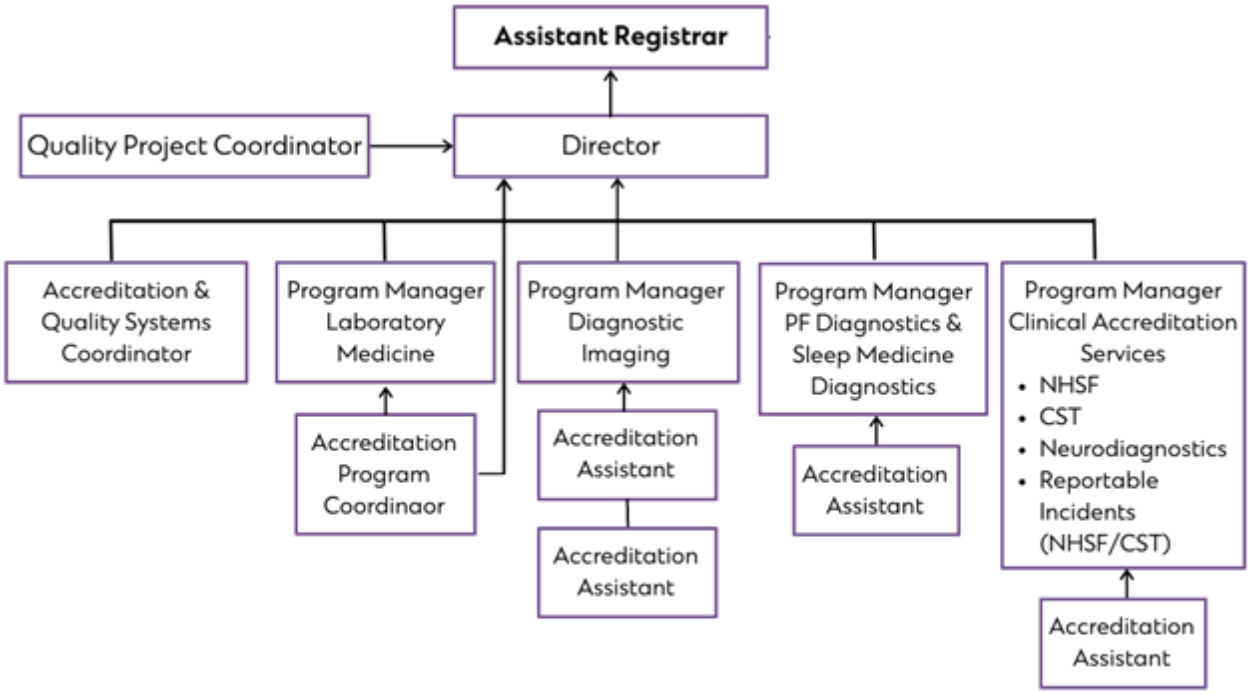
We are innovators.

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)



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 community 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.

A standing committee, the Medical Facility Accreditation Committee (MFAC), oversees CPSA's accreditation programs with members appointed by 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 committee each year to report on the diligence and objectivity of the work conducted.

The six 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 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 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

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.

All facilities performing laboratory examinations 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.

On-going Self-Assessment

CPSA 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. 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 include 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. Many names, including Portable Monitoring (PM) or Ambulatory Testing (AT) otherwise knows it. At a minimum, devices used in HAST must record airflow, respiratory effort, and blood oxygenation levels.

2.8 PERSONNEL

2.8.1 CPSA SMD Accreditation Personnel and Roles

The Assistant Registrar, Department of Accreditation has overall responsibility for the accreditation programs and is supported the Director of Accreditation, the Program Manager for Sleep Medicine Diagnostics and the Accreditation Assistant for the program.

2.8.2 Advisory Committee on Sleep Medicine Diagnostics

The Advisory Committee on Sleep Medicine Diagnostics (ACSMD) advises CPSA's accreditation program for diagnostic 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
- Respond to the needs of Albertans for improved services in Alberta

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) representatives
- Dentists
- Representative from the Alberta Dental Association & College (ADA&C)

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

Assessment Coordinators are consultants 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 sessions 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.

2.9.2 Conflict of Interest/Confidentiality Agreements/Liability

All members of CPSA accreditation committees sign a Confidentiality agreement with CPSA annually. Committee members, Assessment Coordinators and Physician Reviewers are also required to confidential 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 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 documents <u>are consistently organized</u> 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:

Each standard consists of the following components:

Column 1

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

Column 2

- Description of **standard requirement**

Column 3

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

Column 4

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

3.3 ASSESSMENT OF COMPLIANCE

- Although the Assessment of Compliance (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.
- 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.

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.

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 might not always be relevant and/or applicable. Compliance is expected with CPSA Standards not the cited references.

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 laboratories 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 – NEW FACILITIES

4.1 PHASE 1

	Responsibility	Task	Additional Information
1.	Facility	Facility registers on the CPSA website	• All new facility register on the CPSA website for accreditation
2.	CPSA	A new facility application form is sent out the facility	Facility receives the application and completes it within the timeline provided.
3.	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 of any conflict of interest (employment/affiliation)
4.	CPSA	Contact is made with the Medical Director	The Assessment Logistics Form (ALF) is sent directly to the Medical Director. The form asks them to identify a key assessment facility contact.
5.	Facility	Completes ALF Form	Completed form is submitted with signatures to CPSA within the specific timeline.
6.	CPSA	Provides SharePoint access	CPSA sets up secure facility access to the CPSA SharePoint site for the key SMD facility assessment contacts and communicates this information.

4.1.2 PRE-ASSESSMENT

Responsibility		Task	Additional Information
7.	CPSA	Provides <u>each SMD facility</u> to be assessed via SharePoint with a "*Pre-assessment Data Verification" (PADV) Form*	CPSA uploads a copy of the form into the facility folder. 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) • zone managed programs / processes • organizational structure • blank examples of facility examination request (requisitions/consultation) forms and blank screening form/questionnaires)
8.	SMD facility	Completes *PADV form* and uploads to SharePoint with required MD signature within the specified timeline	CPSA follows up directly with the Facility regarding any missing documentation or documentation requiring further clarification.
9.	SMD facility	Uploads assessment materials to SharePoint site	All materials required to complete the assessment, (e.g. manuals, sample forms) are uploaded or links provided for the AC to review.
10.	CPSA	Reviews submitted PADV form and prepares assessment documentation	• accesses completed PADV 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 documentation requiring further clarification. • The AA notifies the AC that the materials are complete and ready to be reviewed.

	Responsibility	Task	Additional Information
11.	AC	Desk Audit	The AC reviews the completed PADV forms, submitted documentation (embedded and uploaded on SharePoint), and prepares an initial citation report, noting identify areas of concern for further follow-up during the assessment. Records the following for each citation in the citation report template: • standard number • compliance assessment category (CPEN) • detailed observation/objective evidence • comments (where applicable)
12.	AC	Determines assessment date in consultation with the facility	Assessments are not scheduled until all assessment documentation is reviewed. AC notifies CPSA of dates.
13.	CPSA	Sends confirmation of team approval and assessment dates to AC and facility	

4.1.3 On-Site Assessment

Responsibility		Task	Additional Information
14.	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
15.	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
16.	SMD 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.
17.	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) ACs apply their 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.

	Responsibility	Task	Additional Information
18.	AC On-site	(cont'd)	Guidance for ACs when assessing facility: 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

	Responsibility	Task	Additional Information
19.	AC On-site	Notify CPSA immediately of any serious deficiencies that may have immediate impact on staff or patient safety	ACs 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 sleep medicine facility personnel for immediate action as deemed appropriate 2. AC will consult with CPSA immediately via telephone

20.	AC
	On-site
		Conduct a summation conference for the SMD 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.
			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 ACSMD to review the draft final report
			  ○ distribution of final report
			  ○ SMD facility responses and submission of EOC
			• Acknowledgement of SMD facility personnel for their cooperation and support of the accreditation process.
			• facility questions

21.	AC	Uploads findings to SharePoint in a citation report	Add citations from the on-site assessment to the initial citation report created during the desk audit. Within 7 days following the assessment the AC will upload their citation report along with any photographs, sample documents, etc. to the SharePoint site.

4.1.4 Post Assessment

Responsibility		Task	Additional Information
22.	CPSA		Creates the Phase 1 facility report
23.	CPSA (PM)	Vets and approves assessment Phase 1 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.
24.	CPSA (Quality System Coordinator)		Reviews/revises the Phase 1 facility report 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
25.	CPSA	Loads the assessment report into the facility's folder on SharePoint, notifies the facility the report is available	

26.	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.
27.	CPSA	Reviews facility responses to requirements, recommendations and requested evidence of compliance.	CPSA reviews the facility responses to the requirements, recommendations, requested evidence of compliance, and provides recommendations to MFAC as to the appropriateness of the response. CPSA reviews the assessment team feedback for consistency prior to MFAC review.
28.	CPSA (Quality System Coordinator)	Reviews/approves facility responses.	Reviews the responses to EOC and the CPSA evaluation to: • eliminate any personal bias • ensure consistent application of the standards • endorse any further EOC requirement and timeline for submission based on risk assessment
29	CPSA	Informs facility they have completed Phase 1	When all citations have been responded to in an acceptable resolution the facility is informed they have completed Phase 1 of the process

4.2 PHASE 2

	Responsibility	Task	Additional Information
30.	CPSA	Request sampling of interpreted reports for independent review	A random sampling of 10 charts from testing done at the facility will be requested 6-8 weeks after the facility has satisfactorily answered all of the citations form the Phase 1 report. 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 SMD facility will be asked to upload the chosen examinations into the electronic portal. Same day upload is optimal. The SMD facility will have 5 business days from the date of the request to provide the documentation. The SMD facility will notify CPSA when the reports are ready for review.
31.	CPSA (Physician reviewer)	Physician reviewer reviews reports	The PR will have one business week to review the reports, associated paperwork, and submit findings back to CPSA via SharePoint.
32.	CPSA	Reviews physician reports	If required citations are added to the assessment report if necessary from the review of the chart report.
33.	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.
34.	CPSA	Reviews facility responses to requirements, recommendations and requested evidence of compliance.	Following the receipt of the responses, CPSA reviews and either approves the SMD facility responses or revises the requested evidence of compliance, with a view to: • acceptability of response / corrective action • further action / clarification required

			EOC may be required for any response based on submitted response, regardless of whether EOC was requested in the initial report. If there are issues or concerns based from responses that require the ACSMD's expertise, CPSA will bring anonymized and redacted issues / themes forward for discussion. The AC will be available at the ACSMD meeting to responding to additional questions or clarification requests (anonymized discussion; the facility will not be named – no identifiers used, e.g. name or facility number. CPSA provides a section in each report to facilitate CPSA responses.
35.	CPSA (Quality System Coordinator)	Reviews/approves facility responses.	Reviews the responses to EOC and the CPSA evaluation to: • eliminate any personal bias • ensure consistent application of the standards • endorse any further EOC requirement and timeline for submission based on risk assessment
36.	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.
37.	CPSA	Provides Certificate of Accreditation and Window Vinyl to display at facility	
38.	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.