cpsa
COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

Accreditation Program Guide

Neurodiagnostics Facilities - 4 year accreditation

March 2023 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 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 neurodiagnostics and resources
- promote standardization and educational initiatives across Canada through inter-provincial collaboration
- promote and encourage dialogue amongst stakeholders on best practices and best ways to incorporate them into the workflow
- ensure effective medical direction over medical practices so that business interests do not determine the standards of care

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

2.1 CPSA LINES OF BUSINESS

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

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

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

CPSA regulates the practices of medicine in Alberta including:

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

2.2 CPSA MISSION, VISION, VALUES

Our vision

Professional, ethical and competent regulated members, providing the highest quality care for all Albertans.

Our mission

To serve and protect all Albertans, contributing to their health and wellness by supporting and guiding regulated members to proudly provide safe, high-quality care, together with healthcare partners and patients.

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.

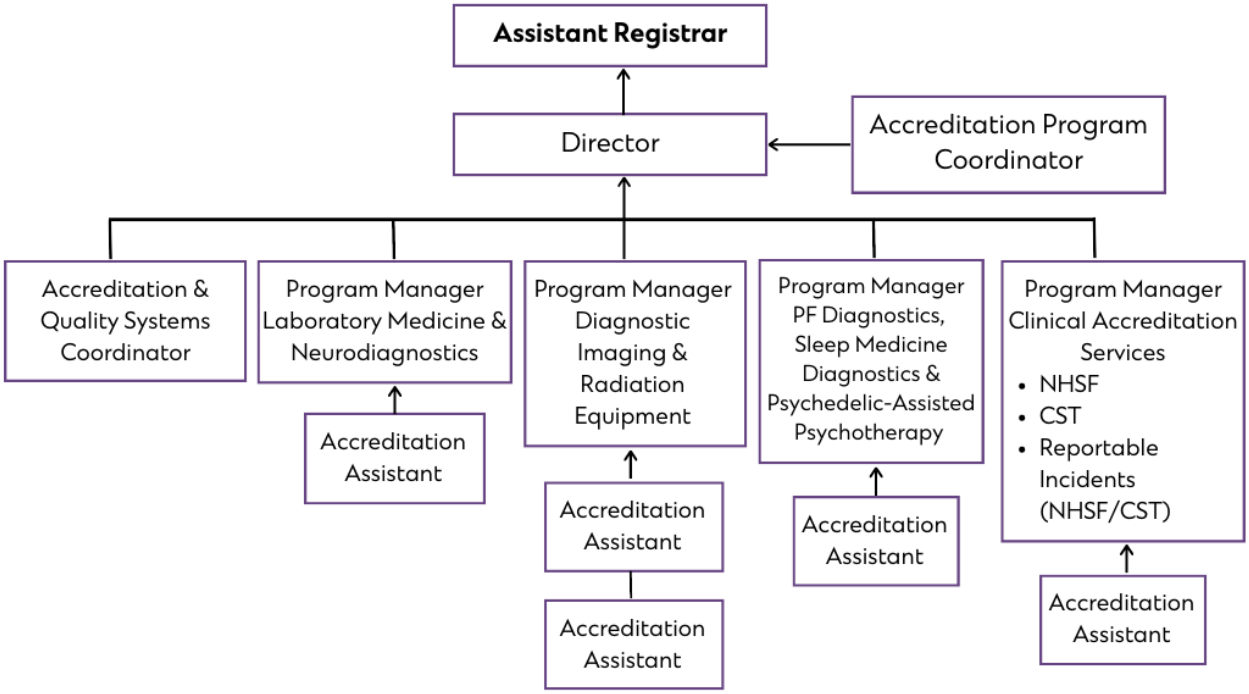
We empower people.
We believe people perform best when they see the Vision, set their own goals, have the resources they need and aspire to excellence and personal growth.

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 DEPARTMENT) - FIGURE 1



CPSA: Feb. 2023

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 includes:

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

2.5 AUTHORITY AND OVERSIGHT

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

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

a) permitting the assessment team to enter the neurodiagnostics 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 neurodiagnostics 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 neurodiagostic services, in the facility;
d) providing the information described in clause (c) in the form requested by the assessment team;
e) providing requested samples or copies of any material, specimen, or product originating from the neurodiagnostics services, provided by the facility;
f) answering questions posed by the assessment team as to procedures or standards of performance and if requested, providing copies of records relating to procedures followed and standards of performance applied in the neurodiagnostics facility;
g) providing requested copies of all documents and information relating to business arrangements involving the practice conducted in the neurodiagnostics 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 neurodiagnostics) are under contract with government agencies such as Alberta Health Services (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 NEURODIAGNOSTICSS 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 Neurodiagnostics Accreditation Program examines all aspects of neurodiagnostics' 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 Neurodiagnostics Accreditation Program is a peer review process with a goal to improve neurodiagnostics service 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.

Assessment Model

The CPSA hybrid model consists of a comprehensive desk audit of submitted materials in advance followed by an on-site assessment focusing risk, patient/staff/safety elements and those activities that require direct observation/validation.

Desk audit assessment includes but is not limited to:

- Policies / processes / procedures
- Formal, controlled templates/documents/forms
- Completed records / logs
- Audit reports
- Site –visit reports
- Training and competency documentation

Benefits of CPSA neurodiagnostics 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 neurodiagnostics facility being accredited and the Assessment 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 and complexity of services, and resources within the province
- Promotes and ensures dialogue amongst neurodiagnostics service 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 NEURO facilities to be assessed
At a minimum NEURO Facilities are assessed initially when opened and placed in a 4 year reaccreditation calendar.
A NEURO facility will be subject to additional assessments for the following circumstances:

- Add service(s)
- Add volume(s)
- Post renovation
- Moved locations
- Unsatisfactory performance complaint
- Post significant disaster (flood, fire, theft, power outage)
- At CPSA request

With 4 year reaccreditation facility assessments, preliminary planning typically occurs in October of the previous year for CPSA's neurodiagnostics program. This preliminary planning involves CPSA's selection of assessment teams and the timeframe for when 4-year reaccreditation facility assessments are to occur in the upcoming year. Also at that time, CPSA notifies the applicable facilities through the Medical Director(s) that reaccreditation is required, and additional information will be requested for submission in the coming months.

On-going self-assessment
The CPSA Neurodiagnostics accreditation 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 unless requested.

The 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:

- 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 FACILITY MODALITY / CLASSIFICATIONS

- Electroencephalography (EEG)
- Electromyography (EMG)/ Nerve Conduction Studies (NCS)
- Evoked Potential (EP)

2.8 PERSONNEL

2.8.1 CPSA NEURO accreditation personnel and roles

The Assistant Registrar for CPSA Accreditation has overall responsibility for the diagnostic accreditation programs and is supported by the Director of Accreditation, the Program Manager for Neurodiagnostics Accreditation Services and the Accreditation Assistants.

2.8.2 Advisory Committee on Neurodiagnostics

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

Roles and responsibilities of the ACN

- Develop and maintain evidence based standards for NEURO practice
- Provide advice to the Medical Facility Accreditation Committee (MFAC) on pending decisions relating to the provision of NEURO services;
- Monitor compliance with CPSA approved standards through on-site assessments for accreditation
- Facilitate the introduction of new technologies
- Provide education to promote safety and quality improvement initiatives
- Respond to the needs of stakeholders for improved neurodiagnostics services in Alberta

ACN Membership

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.

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

The Chair is selected from the membership and appointed by the Medical Facility Accreditation Committee (MFAC). In the absence of the Chair, an alternate will be selected from the members present.

It is the responsibility of the Chair to represent the Committee (either in person or virtually) for any appeals of Committee decisions that are made to MFAC.

Membership is comprised of 9 voting members and 3 non-voting members and includes:

Voting Members:
- *Neurologists*
- *Other qualified physician specialists that interpret neurodiagnostic tests*
- *Neuro-ophthalmologist (recognized in Neurodiagnostic Visual Evoked Potentials)*

-OR-

An individual with a PhD degree with training in Neuro-ophthalmology Visual Evoked Potential Diagnostics

Non-Voting Members:
- Assessment Coordinators

Tenure
Committee members are appointed by MFAC for the following terms:
Chair – Three year term with the option of a one year extension
Voting members – Five year term with the option of a one year extension

2.9 ASSESSMENT TEAMS

2.9.1 Assessment coordinator

Each assessment team will include an Assessment Coordinator who is a consultant of CPSA. Their primary role is to coordinate, organize, and facilitate the assessment process.

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 Neurodiagnostic technologist assessor

Neurodiagnostics facilities with multiple modalities, testing rooms and/or public health care facilities (AHS) CPSA's assessment team size will increase in order to perform the on-site review.

2.9.4 Team selection

CPSA selects the members of the Team which includes experienced individuals. All Team members are provided with the training, information and material necessary by the CPSA to conduct a fair and thorough assessment.

Selection of the Assessment Team is based on:

- scope and complexity of services
- experience of team members
- specific to public health care facilities
    - number/geographic location of facilities
    - requirement for 100% non-AHS assessors

2.9.5 Assessment team training

All assessment team members are required to participate in a CPSA Assessor Training module, within 6 weeks prior to performing an on-site assessment. Following completion of the training module, assessment team members must demonstrate competency by successful performance of an on-line examination.

Upon successful completion of the training module and exam, all assessors receive a continuing professional development certificate.

2.9.6 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.

All 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

Health Professions Act 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.

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 are reviewed and approved by the Advisory Committee on Neurodiagnostics, with final vetting and approval by the Medical Facility Accreditation Committee.

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 (e.g., ANTA, ACNS, CSA, GOC, AANEM[2]). 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.

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

Prior to each assessment, standards documents applicable to the scope of the NEURO services 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

2. *ANTA (Association of Neurophysiological Technologists of Australia Inc.), ACNS (American Clinical Neurophysiology Society (ACNS), CSA (Canadian Standards Association), GOC (Government of Canada), AANEM (American Association of Neuromuscular & Electrodiagnostic Medicine).*

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 current ISO 15189/9001.

All standards documents are consistently organized in the following order (as applicable in each document):

- Organization, Management & Personnel
- Quality Management System
- Physical Facilities
- Equipment, Consumables and Supplies
- Information Systems
- Pre-examination policies, processes and procedures
- Examination policies, processes and procedures
- Quality Assurance of examination procedures
- Post-examination policies, processes and procedures
- Safety
- Infection, Prevention and Control

Figure 2 - Standard Document Format Example

#	Standard	Reference	Assessment of Compliance
ND.1.1 Organization & Management Responsibility			
ND.1.1.1	The facility defines, documents, and communicates the responsibilities, authorities and interrelationships within the organization.	CSA3 26000 - 6.2 CSCN1 ISO1 15189 - 4.1.2.1.d, 4.1.2.5 ISO2 9001 - 5.3 ISQua1 - 3.5 Guidance: An organizational chart may be used to define and document organizational roles and reporting hierarchy	Are the responsibilities, authorities and interrelationships within the facility organization: • defined? • documented? • communicated? Does this include, where appropriate: • medical director? • facility supervisor? • technical / non-technical staff? • 'quality manager'? Are persons appointed to undertake the duties of key management and technical personnel in their absence (deputies)? C ☐ P ☐ E ☐ N ☐ N/A ☐ Observation:

Each standard consists of the following components:

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

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

3.3 ASSESSMENT OF COMPLIANCE (AOC)

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

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

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

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

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

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

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

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

3.4 TERMS AND DEFINITIONS

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

3.5 REFERENCE LISTING

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

3.6 REVIEW AND REVISION OF STANDARDS

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

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

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

- submitted using the Stakeholder Standards Review Form.
- identification of specific standard or section if applicable to multiple standards

- supported by detailed rationale/justification AND verifiable references (link or attachment must be included)
- applicable to all NEURO 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

4.1 INITIATION

In the initiation phase there are five documents for the facility Medical Director review, complete and submit to CPSA neurodiagnostics accreditation program:

- *Assessment Logistics*
- *Proposed Team Member*
- *Medical Director Responsibility*
- *Pre-assessment Data Verification*
- *Stakeholder Survey*

The initiation process has tasks for the CPSA and the Medical Director(s)/facility to complete as itemized in the below chart:

- CPSA = 11 tasks
- Medical Director/facility = 6 tasks

	Responsibility	Task	Additional Information
1	CPSA	• identifies NEURO facilities to be assessed • notifies facility Medical Director (s)	• NEURO facilities revert to Provisional accreditation status throughout the accreditation process • NEURO facilities are given their assessment initiation timelines in advance of the upcoming reaccreditation calendar year
2	CPSA	Selects Assessment Coordinator (AC) and 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	Provides Medical Director with the *Assessment Logistics Form*	The facility Medical Director is requested to complete and sign the *Assessment Logistics Form* which includes: • provision of key facility assessment contact(s) • identification as to the facility personnel that will be issued CPSA access to the secure website based system SharePoint® • approval of proposed Assessment Coordinator

4	**Facility**	Completes *Assessment Logistics Form* and submits it to CPSA	Completed form is submitted with Medical Director' signature(s) to CPSA within the specified timeline CPSA sets-up secure SharePoint® access for the facility's assessment contact(s) and communicates this information
5	CPSA	Advises Medical Director of proposed assessment team members and requests formal written approval using the *Proposed Team Member* Form	For each facility assessment, the facility Medical Director receives a formal document of the proposed Team members including their: • name • scope of assessment activities location of employment/employer
6	**Facility**	Submits to CPSA *the Proposed Team Member* form the Medical Director reviewed and signed regarding the approval of Assessment Team members to CPSA	If any original members are not approved by the facility due to an identified conflict of interest, CPSA will solicit alternate Assessment Team members and request approval.
7	CPSA	Uploads a number of documents into the facility's SharePoint® folder required for its 4 year reaccreditation assessment	The facility's SharePoint® folder will contain: • Current CPSA accreditation standards and requirements that the facility will be assessed by ○ pdf version ○ editable word document version • Facility training webinar
8	CPSA	Provides pre-recorded training sessions for facility personnel	Facility Training focuses on: • overview of assessment process steps • use of the standards tool • assessment logistics & timelines
9	**Medical Director/Facility**	Accesses and reviews the information CPSA uploaded in to the facility's SharePoint® folder	Access and review of CPSA documentation in the facility's SharePoint® folder is required a part of its four year reaccreditation: • Current CPSA accreditation standards and requirements that the facility will be assessed by • Facility training webinar
10	CPSA	Provides *Medical Director*	The DocuSign® electronic platform securely assigns the document to directly to the facility Medical

		Responsibility through DocuSign® electronic platform	Director(s) to review and complete as acknowledgement and agreement to their role(s) and responsibilities as specifically outlined in CPSA Accreditation standards.
11	CPSA	Provides facility to be assessed with a "*Pre-assessment Data Verification*" (PADV) Form	The *PADV* requests submission of the following by the facility undergoing assessment before the AC arranges the date/time of the on-site review: • general facility information • hours of operation • scope of modalities / service • organizational structure • interpreters • examples of examination request forms, consent forms and screening forms • equipment list • list of examinations and services implemented since the last 4 year assessment • complete list of examination procedures • Policy, procedure and process manuals • Sample of patient charts that represent the case mix of the population served by the facility, various technologist, physicians performing testing and those who perform the interpretations. ○ EEG (total of 6 studies) – 2 normal and 4 consecutive abnormal ○ EMG/ Nerve Conduction (total of 10 Studies) – 2 normal and 8 consecutive abnormal (with at least 2 EMG studies) ○ EP (total of 10 Studies) – 2 normal and 8 consecutive abnormal • Other items CPSA pre-populates the form with information in the current CPSA database. Facilities are directed to carefully review pre-populated data.
12	**Facility Medical Director**	Completes *Medical Director Responsibility* attestation form through DocuSign® electronic platform	Formal written facility Medical Director(s)' acknowledgement and agreement to their role(s) and responsibilities as specifically outlined in CPSA Accreditation standards.

13	**Facility**	Completes PADV form and submits along with required documentation and signature to CPSA within the specified timeline into its assigned SharePoint® folder.	CPSA reviews the submission, following up directly with the facility regarding any missing documentation or documentation requiring further clarification. Once the facility provides all requested information then CPSA informs the assessment team's AC to arrange a date/time for the onsite review.
14	CPSA	Provides facility to be assessed with a *Stakeholder Survey* Form	The form requests the facility provide a selection internal and external stakeholders for CPSA to survey: The survey encompasses stakeholder satisfaction with: • Physical facility and utilities • General facility services • Pathologist services • Test menus and turn-around-time • Referral testing services • Communication • Workload • Training and competency
15	**Facility**	Completes *Stakeholder Survey form* and submits to CPSA.	The stakeholders listed by the facility for CPSA contacted will be provided a survey monkey questionnaire as to their satisfaction of • Physical facility and utilities • General facility services • Pathologist services • Test menus 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. These are also uploaded to the facility SharePoint® site for its information.
16	CPSA	Prepares customized assessment supporting documents for provision to Assessors	CPSA prepares customized tools/supporting documentation for AC/assessors: • summary of facility's previous citations and responses referenced to current standards • completed PADV and its required documentation • copy of standards • facility and assessor guides

17	CPSA	Conducts internal and external stakeholder surveys	CPSA sends a link to internal / external client stakeholders to complete a brief on-line survey regarding the neurodiagnostics service. The surveys encompass stakeholder satisfaction with: • physical facility • interpreter services • general on-site services including examination 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. These are also uploaded to the facility SharePoint® site for its information.

4.2 PRE-ASSESSMENT

The pre-assessment phase mostly comprises of tasks for the CPSA. In this phase there is one task of the facility. After the AC books the date and time of the assessment, the facility is required to:

- meeting room for AC
- access to any neurodiagnostics records located outside the facility

4.2 PRE-ASSESSMENT – continued

	Responsibility	Task	Additional Information
1	CPSA/AC	Review facility's submissions for completeness	Once the facility submission is complete, the AC will arrange a date/time for the onsite assessment to occur. All assessment information is provided to team members via their secure SharePoint® site
2	CPSA/AC/Physician Reviewer	Complete desktop review in advance of onsite assessment	A comprehensive desk audit of submitted materials occurs in advance followed by an on-site assessment focusing on patient/staff/safety elements and to identify those activities that will then require direct observation/validation. Desk audit assessment includes but is not limited to: • Policies / processes / procedures • Formal, controlled templates/documents/forms • Completed records / logs • Audit reports • Site –visit reports • Training and competency documentation ○ Review of patient chart sampling ○ EEG (total of 6 studies) – 2 normal and 4 consecutive abnormal ○ EMG/ Nerve Conduction (total of 10 Studies) – 2 normal and 8 consecutive abnormal (with at least 2 EMG studies) ○ EP (total of 10 Studies) – 2 normal and 8 consecutive abnormal
3	CPSA/AC/Physician Reviewer	Chart review findings	The desk audit chart review services two purposes: ○ Facility focused to determine if policies, procedures and processes for testing services are in place and followed by technologists, physicians performing the tests and those completing the interpretations. ○ Deficiencies found will be cited in the report the facility receives post assessment ○ CPSA member peer review ○ Feedback is directly provided to the facility physicians for quality improvement. ○ This information is not

	Responsibility	Task	Additional Information
4	CPSA/AC	Coordinates facility logistics with the facility assessment contact	The AC determines the date and time of the onsite assessment with the facility. The AC also informs the facility contact items ready and be available at the time of the onsite: • meeting room for AC • access to any neurodiagnostics records located outside the facility
5	CPSA/AC	Provides formal confirmation of the onsite assessment date and time	Email confirmation is provided by CPSA indicating the date and time for record keeping purposes

4.3 ON-SITE ASSESSMENT

The onsite assessment process involves a review of the formal and informal practices of the facility that focus on standards that are deemed to have a high risk to patient/staff/safety if there is a non-conformance. As well, the on-site assessment will focus on activities that require direct observation/validation to ensure that the standards is being met.

	Responsibility	Task	Additional Information
1	AC	Conducts an opening meeting with facility personnel	At the beginning of the on-site assessment at each facility, the AC conducts an opening meeting for the facility personnel that encompasses: • introductions • assessment logistics and timelines • assessment process outline
2	**Facility**	Provides access to the facility for AC to complete the onsite assessment	The flow through the NEURO facility follows the process in which a patient test is conducted. A high level overview of the facility layout its operation and key personnel is a great ice-breaker and sets the stage as a collegial space. It is important that the AC and accompanying assessors are shown: ○ Location of bathrooms for the assessment team to utilize ○ Emergency evacuation route and muster-point ○ Introducing the AC to facility personnel and patients when those encounters occur during the assessment
3	AC/Assessors	Conduct on-site assessment	**The Assessment Process – General:** The Accreditation assessment process involves: • verifying **compliance** with the intent of accreditation standards • follow-up of previously identified areas of concern • interaction with staff at all levels • interaction with physicians and other health care providers **Assessor Behavior:** • engage in clear and concise dialogue with facility staff • explain the assessment process to facility staff, as required • exhibit positive body language

	Responsibility	Task	Additional Information

			• assess according to the standards (unbiased approach)
			  ○ there are many ways to meet the intent of a standard
			• adopt an educational rather than a consultative OR punitive approach
			  ○ the goal of the assessment is improvement
			• do not act as a consultant
			• be conscious of timelines, assessment schedules and obligations
			
			The CPSA Assessment Tool:
			
			The on-site assessment is performed using the facility specific standards document tools.
			
			Assessment of Compliance
			
			• The AOC questions address the key evidence required to meet the intent of each standard.
			• Evidence of alternate policy, procedure, and process that the facility has implemented with Medical Director approval to achieve compliance with the standard is taken forward to CPSA for evaluation.
			• Where AOCs state "all of the following", compliance with all elements is expected (e.g. test request form).
			• Assessors' expertise and CPSA guide enables inter-assessor reliability for consistency of all facility assessment.
			• Facility compliance with the standard is assessed by review of documents and records, observation and discussion.

4	AC/Assessors	Conduct on-site assessments	**When assessing facility:**
			• **It is not possible to review the entire scope of facility operations**
			  ○ focus on areas of highest and lowest examination volumes, likely problem areas and examination 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

	Responsibility	Task	Additional Information
			○ utilize **CPSA Assessor Guides** to focus / direct assessment • **Review documents, policies, processes and procedures(PPPs) and records** ○ the assessor should choose a random, representative selection of documents and records to review ○ assessors should not rely solely on documents/records chosen or selected by the facility for review • **Observe activities:** ○ 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: ▪ tracer method: follow a patient 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 • **Determine the scope and nature of potential citations:** ○ is there a P/P/P? ○ Is the P/P/P in compliance with the standards? ○ is the P/P/P 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? • **Discuss / confirm potential deficiencies with facility representatives**

	Responsibility	Task	Additional Information
5	AC/Assessors	Conduct on-site assessments	• **Record objective evidence:** ○ as immediately as possible after encountering citation ○ using the customized assessment tool (paper or electronic) ○ do not rely on memory ○ be factual and thorough ○ provide ample background detail for interpretation and determination by CPSA of the requirement/EOC • **Photographic evidence for the Advisory Committee:** ○ for safety related citations, consult with AC for necessity to corroborate observation with photographic evidence ○ AC will be responsible for notifying the facility contact and taking required photographs ○ AC will ensure that no individuals or confidential information are identifiable in the photographs **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)

	Responsibility	Task	Additional Information

22	AC/Assessors	Notify AC/CPSA immediately of any serious deficiencies that may have immediate impact on staff or patient safety	• **Exceeds requirement citations (E)**
			  ○ recognize 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.
			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 testing personnel for immediate action as deemed appropriate
			#2 - AC who will consult with CPSA immediately via telephone

6	AC/Assessors	Communicate PEN findings (assessors) to AC while on-site	**PEN Findings:** The AC will determine and communicate the timelines and frequency for debriefing assessors to obtain assessment PEN findings. AC will ask assessors to provide the following for each citation and record the details in the citation recording template: • Standard number (if known) • Compliance assessment category (PEN) • Detailed observation/objective evidence • Comments (where applicable) The AC ensures all citations include sufficient and clear detail in the objective evidence to facilitate CPSA determination of the requirement, EOC and timeline for EOC. If the assessor and/or AC is unable to determine the appropriate standard number to reference the citation, ACs are advised to record the other citation details and CPSA will make the determination.

	Responsibility	Task	Additional Information

7	AC	Conduct a summation conference for the 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.)
			• Overview of the next steps in CPSA accreditation process including timelines for:
			  ○ distribution of final report
			  ○ facility responses and submission of EOC
			• Acknowledgement of facility personnel for their cooperation and support of the accreditation process.
			• Facility questions

4.4 POST ASSESSMENT

The post assessment process involves the generation of the formal report by the CPSA. The report is provided to the Medical Director and the facility's assessment contact to review and comply with the requirements identified.

	Responsibility	Task	Additional Information
1	CPSA	Formats and finalizes draft facility reports	Based on the citation recording summaries provided by the AC, CPSA completes/finalizes the following for each facility report: • Facility demographics and key personnel • Assessment information and team details • Accreditation process dates • Facility Overview • Citations: o Standard number o Safety Risk category o Compliance assessment category (PEN) o Detailed observation/objective evidence o Requirement o Evidence of Compliance (where applicable) o Timeline for submission of EOC Guidelines for requirement of 30 day EOCs: • Significant safety issue All other requests for 90 day EOCs are based on the judgment of the assessors/CPSA and include but are not limited to the following: • All 'P' – 'In Progress' citations • Issues cited on previous assessment reports • All requirements categorized as PS/SS CPSA ensures consistent/uniform: • application of the standards based on similar observations • wording of requirements and EOC • timelines for submission of EOC
2	CPSA	Sends any items that require advice to ACN	• presents any themes or items that require ACN advice, these are presented in an anonymized fashion

4.4 POST ASSESSMENT - continued

	Responsibility	Task	Additional Information
3	CPSA	Any desk audit chart review deficits by Physician reviewer	Physician Reviewer completes the chart review within one business week and submits findings back to the CPSA via SharePoint® The chart review is not meant to assess individual specialist competency; it is rather a benchmark of quality examinations and processes.
4	CPSA/CPSA Quality Systems Coordinator	Reviews Report	Reviews / revises the NEURO facility assessment citations to: • eliminate any personal bias • ensure consistent application of the standards from one Assessor / assessment to another • endorse EOC requirement and timeline for EOC submission based on risk assessment • ensure standards / requirements reflect current best practice
5	CPSA (Accreditation Assistant)	Prepares and distributes final facility reports to Medical Director(s)	• format reports to include a section for a facility response to each individual non-conformance/ in-progress citations • posts the finalized individual facility reports on the secure CPSA SharePoint® site • notifies the Medical Director of the facility and a designated distribution contact that the final reports are available electronically
6	CPSA	Provides accreditation evaluation forms to facilities and assessors	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 Forms. Stakeholders are afforded the opportunity for anonymous comment. Results are compiled and reviewed annually by CPSA. Changes to process are implemented as appropriate based on feedback.

4.4 POST ASSESSMENT - continued

	Responsibility	Task	Additional Information
7	Facility	Submits a response to requirements and requested evidence of compliance	Facilities are required to input their response directly into the report and embed any requested supporting documentation/EOC as applicable. Responses are uploaded to secure facility SharePoint® site. **For requirements with requests for EOC**: Facilities must provide a response and required EOC based on timelines specified in the report (30 or 90 days from the date of the report). **For requirements without requests for EOC**: Facilities must provide a response within 90 days from the date of the report.
8	CPSA	Reviews facility responses to requirements and requested evidence of compliance	• reviews responses to requirements and requested evidence of compliance and presents to ACN, in an anonymized fashion, if any advice is required or responds to facility if no advice from ACN is required
9	CPSA/CPSA Quality System Coordinator	Reviews 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
10	CPSA	Communicates to AC/assessors	• once first responses are received sends communication to AC/assessors to confidentially destroy documents and delete electronic files
11	CPSA	Responses back to facility	• moves "Response Acceptable" rows to end of report with a heading of Acceptable Responses, adds to list as further responses are deemed acceptable

4.4 POST ASSESSMENT - continued

	Responsibility	Task	Additional Information
12	CPSA	Grants Full accreditation status	CPSA determines if any outstanding non-conformances (either due to volume or type of non-conformances) would substantiate a reversion to "Provisional" status. If this decision is made, a "Provisional" certificate is issued and the facility is advised to replace their "Full" certificate with the "Provisional" certificate. Once the identified "provisional" non-conformance(s) are satisfactorily addressed, the facility is granted "Full Accreditation" status. A certificate is issued once approval has been given by the Medical Facility Accreditation Committee. If a facility is denied accreditation, the facility may access CPSA's formal appeal process.

5.0 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 Administration Fee.

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

6.0 Honoraria and Expense Reimbursement

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