cpsa
COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

Accreditation Program Guide

Pulmonary Function Diagnostics - 4 year accreditation

DECEMBER 2022 V5

1.0 Purpose of Accreditation

Accreditation is defined as the public recognition of quality achievement by a healthcare organization, as demonstrated through an independent external peer comparison of the organization's performance against current best practices.

The College of Physicians & Surgeons of Alberta (CPSA) diagnostic accreditation programs:

- assist facilities with a process of ensuring accuracy and reliability of examination/services
- provide standards of practice and assess compliance to these standards
- identify deficiencies that affect the quality of examination/services, and impact patient and/or staff safety
- evaluate a facility's quality system's ability to identify and mitigate risk and variability in system processes
- gives formal recognition of a facility's provision of quality diagnostic services
- encourage and facilitate peer review
- provide educational opportunities for both the facility being accredited and the Assessment Team
- promote uniformity in practice provincially, where variations in practice are counter-productive for the province
- maintain a comprehensive data repository for scope of service/levels of imaging and resources
- promote standardization and educational initiatives across Canada through inter-provincial collaboration
- promote and encourage dialogue amongst stakeholders on best practices and best ways to incorporate them into the workflow
- ensure effective medical direction over medical practices so that business interests do not determine the standards of care

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

2.1 CPSA LINES OF BUSINESS

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

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

CPSA regulates the practices of medicine in Alberta including:

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

2.2 CPSA MISSION, VISION, VALUES

Our vision

The highest quality medical care for Albertans through regulatory excellence.

Our mission

Serving the public by guiding the medical profession.

Our values

We do the right thing.
We act responsibly, respectfully and with integrity, aspiring to be fair and responsible. We acknowledge our mistakes as well as our successes, and strive to do what's right in the service to the public.

We make informed decisions.
Our decisions are based on evidence, knowledge, experience and best practice. We plan, measure outcomes and apply what we learn.

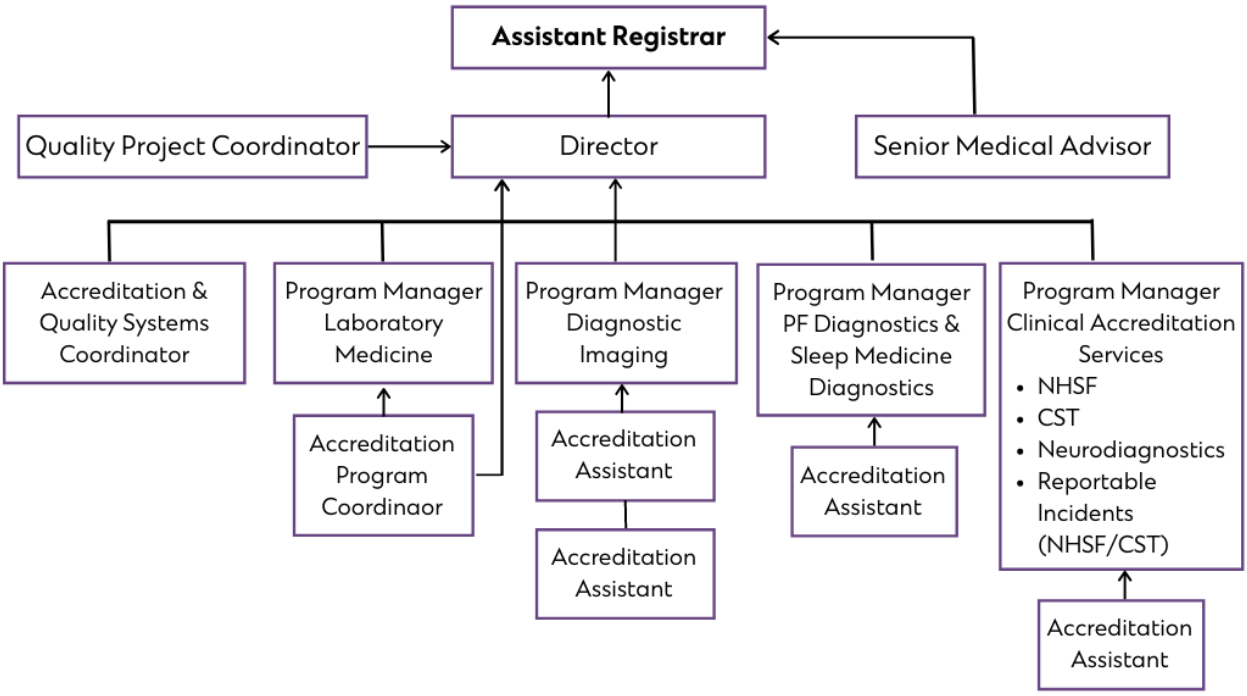
We empower people.
We believe people perform best when they see the Vision, set their own goals, have the resources they need and aspire to excellence and personal growth.

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



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 facility and assess the premises and all diagnostic equipment located therein;
b) permitting the assessment team to assess all records pertaining to the provision of Pulmonary Function Diagnostics services, and providing copies of the same if so requested;

c) providing to the assessment team information requested by them in respect of the provision of Pulmonary Function Diagnostics services in the facility;
d) providing the information described in clause (c) in the form requested by the assessment team;
e) providing requested samples or copies of any material, specimen, or product originating from the Pulmonary Function Diagnostics services, provided by the facility;
f) answering questions posed by the assessment team as to procedures or standards of performance and if requested, providing copies of records relating to procedures followed and standards of performance applied in the Pulmonary Function Diagnostics facility;
g) providing requested copies of all documents and information relating to business arrangements involving the practice conducted in the Pulmonary Function Diagnostics facility.

Although CPSA's statutory authority does not extend to health services in approved hospitals or healthcare facilities operated by the Government of Canada or the Government of Alberta (*Health Professions Act* Schedule 21 - 8.1(1)), the value of practice uniformity between the private and public sectors and the credibility of CPSA's programs have long been acknowledged by practitioners and government. Consequently, four of CPSA's accreditation programs (laboratory medicine, diagnostic imaging, pulmonary function and neurophysiology) are under contract with government agencies (AHS) to provide accreditation of public sector facilities.

CPSA's accreditation programs are overseen by a standing committee, the Medical Facility Accreditation Committee (MFAC), with members appointed by the Council from diverse disciplines in clinical and diagnostic medicine. MFAC conducts a secondary review of practice standards developed by the accreditation advisory committees, hears argument on all changes to accreditation standards and reviews all facility accreditation and physician approval statuses. A member of the MFAC also attends a full meeting of the individual accreditation advisory committees each year to report on the diligence and objectivity of the work conducted.

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

2.6 OVERVIEW OF PULMONARY FUNCTION DIAGNOSTICS (PFD) ACCREDITATION PROGRAM

CPSA administers accreditation programs for those services that Council determines deserve explicit standards and verification of compliance with those standards, whether pertaining to the qualifications of physicians who provide them or the safety of those services to the public.

Accreditation looks at compliance, emphasizing continuous quality improvement and promoting optimum performance. More specifically, CPSA's accreditation program looks closely at policies, processes and procedures to assess the safety and reliability of the service being provided, as well as the performance of the people involved and the product produced.

The Accreditation Program examines all aspects of Pulmonary Function Diagnostics (PFD) testing quality and operations, including:

- organization, management and personnel
- quality management systems including policy, process and procedure
- physical facilities
- equipment, supplies, consumables
- information systems and archival storage
- pre-examination, examination and post-examination activities
- quality assurance activities
- safety
- infection, prevention and control

The PFD Accreditation Program is a peer review process with a goal to improve service provision and performance through objective evaluation. Assessors evaluate facility compliance with the specific requirements of a standard based on objective observation and assessment. All accreditation assessment findings are vetted by the Advisory Committee on Pulmonary Function Diagnostics to eliminate any potential personal assessor bias, ensure a consistent and thorough approach for all facilities, and to review standards for applicability to current best practice.

Benefits of CPSA laboratory accreditation program

- Assists facilities with the process of ensuring accuracy and reliability of testing/services
- Provides standards of practice and assesses compliance to the standards
- Identifies deficiencies that affect the quality of testing/services, as well as patient and staff safety

- Provides educational opportunities for both the facility being accredited and the inspection team
- Promotes uniformity in practice provincially – where variations in practice are counter-productive for the province.
- Promotes standardization and educational initiatives across Canada through interprovincial collaboration
- Maintains a comprehensive data repository for scope of service/modalities/levels of testing and resources within the province
- Promotes and ensures dialogue amongst providers and administrators on best practices and best ways to incorporate them into the workflow.
- Encourages and facilitates peer review.
- Ensures effective medical direction over medical practices so that business interests do not determine the standards of care.

Confidentiality
All assessment findings are confidential and are only disclosed to parties explicitly associated with an assessment. Documented consent must be obtained from the assessed facility for release of assessment findings or accreditation certificates to other parties.

Frequency and selection of laboratories to be assessed
Pulmonary Function Diagnostic Facilities are assessed initially when opened, subsequently on a four year rotation and if they relocate their facility to a different physical location. This does not preclude an interim assessment that may be required as a result of expansion of services.

At the beginning of the year, all facilities in the area due to be assessed are identified and the Assessment Coordinator is assigned. All facilities performing laboratory examination for patient management, with the exception of physicians doing basic testing, are required to undergo an assessment.

After a new facility is registered and initially accredited, it will then be added in to the regular 4-year cycle. If the timing of this next 4-year cycle is very close to when the new facility was accredited, CPSA may choose not to re-assess the facility.

On-going self-assessment
CPSA Pulmonary Function Diagnostics Accreditation General Standards requires facilities to conduct formal internal audits of all system elements, both managerial and technical, at a frequency defined in their quality management system. Facilities are not required to submit audit findings to CPSA.

CPSA accreditation standard tools are a significant resource for self-audits as they promote a constant state-of-readiness. Laboratories are able to customize the standards tools by:

- tailoring to scope of testing
- documenting/embedding links to policies, processes, procedures, records, forms and labels beside the relevant standard
- utilizing the tool for the performance of comprehensive or targeted audits in between the 4-year CPSA assessments

2.7 LABORATORY CLASSIFICATION

2.7.1 Level II

(Providing a PFT consultation for other physicians)
Tests:

- Vital capacity (VC)
- Timed vital capacity
- Forced expiratory volume in the first second (FEV1) (before and after bronchodilator)
- Forced vital capacity (FVC) (before and after bronchodilator)
- FEV1/FVC (before and after bronchodilator)
- Inspiratory and expiratory flow volume loop (before and after bronchodilator)

2.7.2 Level III

All of the tests included in Level II plus:

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

2.7.3 Level IV

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

- Advanced cardiopulmonary exercise testing including serial measurements of: oxygen uptake, carbon dioxide production, arterial blood gases (if applicable), and cardiac output during progressive exercise.
- Lung compliance (with esophageal balloon for pleural pressure estimation) and pressure volume curve.
- Chemosensitivity assessment, including ventilatory response to hypercapnia and hypoxia and occlusion pressure (P.1).

- Xenon ventilation and perfusion studies.
- Specific inhalation challenge studies.
- Respiratory muscle assessment including one or more of: transdiaphragmatic pressure (Pdi), respiratory muscle EMG, magnetometer or impedance measurement of chest and abdominal movements.
- Respiratory resistance by oscillation or Mead/Whittenberg technique.
- In subjects under the age of 5 years: assessment of pulmonary function by impulse oscillometry, whole body plethysmography, or rapid thoracic compression.
- Transcutaneous measurements of oxygen and carbon dioxide.

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

2.8 PERSONNEL

2.8.1 CPSA pulmonary function diagnostics accreditation personnel and roles

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

2.8.2 Advisory Committee on Pulmonary Function Diagnostics (ACPFD)

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

Roles and responsibilities of the ACPFD

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

- Monitor compliance with CPSA approved standards through reviewing on-site assessment accreditation reports;
- Provide education to promote safety and quality improvement initiatives;
- Respond to the needs of stakeholders for improved services in Alberta
- Review and audit of the business practices of the facility to ensure compliance with relevant CPSA by-laws and standards.

Membership
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. 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 a minimum of 7 voting members and 5 non-voting members.

For voting members, representation includes but is not limited to the following:
- Respirologists
- Pediatric Respirologist
- Physiologist

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. During the assessment they look at the facility's policies, processes and procedures and will examine the records and evidence of implementation of the facility's policies, processes and procedures. Pulmonary Function Diagnostics Accreditation is a process-based audit model; it is not possible to directly assess every individual standard for the entire scope of service provision.

While performing assessments for CPSA, Assessment Coordinators are advised not to display conduct that can be reasonably construed as a solicitation or offer consultant services that may compromise the objectivity of the assessment.

Assessment coordinator training
All Assessment Coordinators are required to participate in CPSA training sessions before being allowed to perform any on-site assessments. Following completion of the training sessions, they must demonstrate competency by successful completion of an on-line examination.

Upon successful completion of the training sessions and exam, all Assessment Coordinators receive a continuing professional development certificate.

2.9.2 Physician reviewer

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

2.9.3 Conflict of interest / vaccination status / confidentiality agreements / liability

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

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

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

While performing assessments for CPSA, assessors are advised not to display conduct that can be reasonably construed as a solicitation or offer consultant services that may compromise the objectivity of the assessment.

CPSA's liability insurance specifically extends to cover Assessment Coordinators who are contracted or act as agents. As well, HPA section 126(1) extends liability protection to all CPSA staff, contractors and agents.

3.0 Standards Document

3.1 STANDARDS OVERVIEW

The Standards are the basis for accreditation decisions and are compiled by CPSA and stakeholder experts, they are reviewed and approved by the Advisory Committee on Pulmonary Function Diagnostics, with vetting and approval by the Medical Facility Accreditation Committee, with final vetting and approval by the Council of the College.

The Standards are evidence based and reference accepted best practices, Provincial and Canadian legislation, relevant International Organization for Standardization (ISO) standards, and other recognized provincial, national and international standards. Each accreditation standard has an accompanying reference citation(s).

All standards included in the documents are mandatory requirements for accreditation.

The Standards are process-based and incorporate a quality management system approach. The language, terms and organization of the documents are consistent with ISO 15189, where relevant.

A review of accreditation standards occurs on an ongoing basis considering and incorporating stakeholder feedback. Comprehensive formal review occurs on an annual basis.

All accredited Alberta PFD facilities Medical Directors receive a complete standards document set. CPSA accredited facilities and other approved users may access, print or make a copy of the standards for their non-commercial personal use. Any other reproduction in whole

or in part requires written permission from CPSA and the material must be credited to CPSA.

Prior to each assessment, standards documents applicable to the scope of the Pulmonary Function Diagnostics services of a facility will be made available to:

- Facilities for self-assessment and/or to prepare for an on-site CPSA assessment.
- CPSA assessors in preparation for on-site assessments and to record objective evidence/observations while performing on-site assessments.

IEEA accreditation

On April 19, 2022 at a meeting of the Board Accreditation Committee of the International Society for Quality in Health Care External Evaluation Association (IEEA) the CPSA Standards for Pulmonary Function Diagnostics Accreditation received IEEA accreditation (effective May 2022 through to May 2026).

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.

The standards document is organized in the following order:

- Organization, Management & Personnel
- Quality Management System (QMS)
- Physical Facilities
- Equipment, Consumables and Supplies (ECS)
- Information Systems (IS)
- Pre-examination Policies, Processes & Procedures
- Examination Policies, Processes & Procedures
- Post-examination Policies, Processes & Procedures
- Safety
- Infection Prevention & Control (IPC)
- Terms and Definitions
- References
- Appendix A: Requirements for Alberta Diagnostic Pulmonary Function Facilities and Services

Standards Document Format Example - Figure 2

#	Standard	Reference	Assessment of Compliance
PF.7.3	**Examination – Spirometry**		
PF.7.3.2 **PS**	Spirometry examinations are appropriately conducted and reflect current best practice.	ATS[1] – Chapter 6 ATS[2] ATS[4] CPSO[1] – Chapter 19, 20 Ruppel[1] – Chapter 2	Are spirometry examination protocols in compliance with accepted best practice? Are there exclusions criteria for spirometry testing that include, but not limited to, patient with cardiac instability? Does the interpretation for spirometry results include : • reference equations for individual's ≥ 19 years of age, with the lower limit of normal (i.e. lower 5% interval) reported? • prediction equations for individuals < 19 years of age, with the lower limit of normal (i.e. lower 5% interval) reported? • ethnicity correction at the discretion of the medical director and notification on the PFT report if applied as a reference set for an individual's spirometry? Do parameters to evaluate spirometry values include at a minimum; • forced vital capacity (FVC)? • forced expiratory volume in the first second to forced vital capacity ratio (FEV_1/FVC)? • peak expiratory flow (PEF)? Is there a procedure for patients on supplemental oxygen?
			C □ P □ E □ N □ N/A □
			Observation:

Each standard consists of the following components:

Column 1

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

Column 2

- Description of standard requirement

Column 3

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

Column 4

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

3.3 ASSESSMENT OF COMPLIANCE (AOC)

- Although the AOC questions address the key evidence required to meet the intent of each standard, they **are not meant to be all encompassing**.
- There may be other evidence that demonstrates compliance with the intent of the standard. Individual assessors apply their own expertise in determining compliance with each standard.
- Compliance with the standard may be assessed by review of documents and records, observation, interviews or a combination of these techniques.
- Where AOCs state "All of the following", compliance with all elements is expected to achieve compliance with the standard.

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

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

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

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

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

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

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

3.4 TERMS AND DEFINITIONS

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

3.5 REFERENCE LISTING

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

3.6 REVIEW AND REVISION OF STANDARDS

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

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

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

- submitted using the Stakeholder Standards Review Form.
- identification of specific standard or section if applicable to multiple standards
- supported by detailed rationale/justification AND verifiable references (link or attachment must be included)
- applicable to all diagnostic laboratory facilities across the province and are not limited to organization specific practice
- contact information included for use by CPSA if clarification of submission is required

4.0 Accreditation Process – 4-year Re-accreditation

		CPSA	ZONE/PFD FACILITY	ASSSESSMENT COORDINATOR	PHYSICIAN REVIEWER
Initiation	January of Assessment year				
Pre-Assessment	16 weeks prior to assessment	1, 2, 3			
	12-16 weeks prior to assessment	5, 6, 7	4		
	8-12 weeks prior to assessment	11	8, 9	10	
	4-6 weeks prior to assessment			12	12
	2-4 weeks prior to assessment	13			
On-site assessment	Day of assessment		15	14, 16, 18, 19	
Post on-site	ASAP after each PFD facility on-site assessment			20	21
	Prior to Advisory Committee meeting / Meeting	22			
	Advisory Committee meeting	23			
	Within 15 business days of Committee meeting	24			
	30/90 days past report distribution		25		
	Review facility responses to requirements, recommendations and requested evidence of compliance.	26		26	
	Next Advisory Committee meeting post response receipt	27			
	Next MFAC meeting post response receipt.	28			
	Year end	29			

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

4.1 INITIATION ASSESSMENT TIMELINE

Responsibility		Task	Additional Information
1.	CPSA 16w prior to assessment	• identifies facilities to be assessed • notifies PFD facility Medical Director(s)	• All facilities revert to provisional accreditation status throughout the accreditation process • Facilities are given their specific assessment initiation timelines at the beginning of the assessment calendar year.
2.	CPSA 16w prior to assessment	Selects Assessment Coordinators (AC)	Potential conflicts of interest are considered when selecting proposed AC(s)
3.	CPSA 16w prior to assessment	Provides facility to be assessed with the *Assessment Logistics Form*	The facility Medical Director is requested to complete and sign the *Assessment Logistics Form* which includes: • provision of key assessment/accreditation contacts • approval of proposed Assessment Coordinator(s) and Physician Reviewer
4.	Facility/Zone 12-16w prior to assessment	Completes *Assessment Logistics Form* (ALF)	Completed form is submitted with signatures to CPSA within the specified timeline
5.	CPSA 12-16w prior to assessment	SharePoint access	CPSA sets up secure SharePoint access for the key zone assessment contacts identified in the ALF and communicates this information.
6.	CPSA 12-16w prior to assessment	Distributes relevant assessment tools (Standards documents) to zone/group/facilities	There may be individual sections and standards within sections that are not applicable to each facility. Assessors will not be assessing these specific requirements.

4.2 PRE ASSESSMENT

Responsibility		Task	Additional Information
7.	CPSA 12-16w prior to assessment	Provides each PFD facility to be assessed via SharePoint with a "*Pre-assessment Data Verification" (PADV) Form*	CPSA initially pre-populates the form with information in the current CPSA database, and facilities are directed to carefully review pre-populated data prior to resubmission to CPSA. The PADV requests submission of the following for each individual facility undergoing assessment: • general facility information • hours of operation • key facility personnel (including those that CPSA will interview via teleconference ~ 1 week prior to the assessment) • scope of modalities (services) • zone managed programs / processes • organizational structure • blank examples of facility examination request (requisitions/consultation) forms and blank screening form/questionnaires)
8.	PFD facility 8-12w before assessment	Completes *PADV form* and uploads to SharePoint with required signature within the specified timeline	CPSA follows up directly with the Facility regarding any missing documentation or documentation requiring further clarification.
9.	PFD facility 8-12w prior to assessment	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.	AC 8-12w prior to assessment	Determines assessment date in consultation with the facility	Assessments are not scheduled until all assessment documentation is received. CPSA sets up assessment team access to SharePoint and sends notification AC notifies CPSA of dates.
11.	CPSA	Sends confirmation of team approval and assessment dates to AC and facility	

Responsibility		Task	Additional Information
12.	Assessment team 2-4w prior to assessment	Reviews assessment documentation and materials in preparation for the on-site assessment.	Each assessment team member is expected to review the assessment documentation to ensure that they are adequately prepared to perform a thorough and efficient assessment. The primary purpose is to: • become familiar with the standards • become familiar with the scope of service including which programs/processes are zone managed • identify areas of concern for further follow-up during the assessment (previous citations)
13.	CPSA 1-2w prior to assessment	Conducts internal PFD and external stakeholder surveys	CPSA sends a link to internal / external client stakeholders to complete a brief on-line survey regarding the PFD service. The surveys encompass stakeholder satisfaction with: • physical facility • services • general on-site services including test menu and turn-around time • referral testing services • communication • workload • training and competency Survey findings are reviewed by CPSA staff. Any significant findings are summarized and provided to the assessment team for corroboration.

4.3 ON-SITE ASSESSMENT

Responsibility		Task	Additional Information
14.	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
15.	PFD facility	Conducts facility tours for assessment team members	An initial tour of the entire facility will give a general overview of the operation and key personnel.
16.	AC On-site	Conduct on-site assessments	**CPSA Assessment Tool:** The on-site assessment is performed using the facility specific standards document tools. Each assessor must utilize the Standards as a tool. **Assessment of Compliance** • Although the AOC questions address the key evidence required to meet the intent of each standard, they are not meant to be all encompassing. • There may be other evidence that demonstrates compliance with the standard. Where AOCs state "all of the following", compliance with all elements is expected (e.g. test request form) Individual assessors apply their own expertise in determining compliance with each standard. Compliance with the standard may be assessed by review of documents and records, observation, interviews or a combination of these techniques. Guidance for Assessors:

Responsibility		Task	Additional Information
17.	AC On-site		When assessing facility sections: It is not possible to review the entire scope of operations • focus on areas of highest and lowest pulmonary function diagnostics volumes, likely problem areas and pulmonary function diagnostics results with highest impact on patient care • directly assess ALL standards with either a PS or SS designation • verify that all non-conformances cited on the previous assessment have been corrected • utilize CPSA Assessor Guides to focus/direct assessment • Review Zone managed programs/processes • Review documents (policies, processes and procedures - PPPs) and records • the assessor should choose a random, representative selection of documents, records and reports to review **Assessors should not rely solely on documents, records and reports chosen or selected by the facility for review.** Observe activities: • engage in meaningful dialogue with facility clinical and non-clinical staff (ask open ended questions such as: (what, when, where, why, who, how) • compare observed activities to the facility policies, processes and procedures • use techniques, such as: • tracer method: follow a sample through pre-examination, examination & post-examination • drill-down: further investigate areas of concern • show/teach me: staff members describe a procedure as they perform it Gather information: • always seek corroboration/validation/verification of findings • evaluate for significance

Responsibility		Task	Additional Information
	AC On-site	(cont'd)	If the assessor determines (due to professional judgement) that the facility will require a Physician Reviewer intervention, they will start to collect examination information (accession numbers) of random examinations as per the 'minimum' number of exams 8.0). They will take this information to the AC; the AC will forward to CPSA. When the report is discussed at the ACPFD, and the decision is to involve a PR, the site will be asked to submit the examinations that the assessor listed. Determine the scope and nature of potential citations: • is there a P/P/ or P? • is the P/P/ or P in compliance with the standards? • is the P/P/ or 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 PFD facility representatives Record objective evidence: • as immediately as possible after encountering citation • using the assessment standards 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 safety related citations, consult with PM for necessity to corroborate observation with photographic evidence • AC will be responsible for notifying the PFD facility contact and taking required photographs • AC will ensure that no individuals or confidential information are identifiable in the photographs

Responsibility		Task	Additional Information
	AC On-site	(cont'd)	Compliance Assessment Categories: Non-conformances (N) • failure to meet the intent and/or requirement of the standard The standards are process based and a single non-compliance may encompass one or more observations. In-progress citations (P) • working towards meeting intent and requirements of standard; assessor notes evidence of timely progress towards full compliance • require submission of future evidence of compliance based on direction from the assessor and/or the Advisory Committee • examples where this assessment may be applied include situations such as: equipment purchased but not on-site and/or implemented; renovations in progress but not complete • are not meant to address partial or incomplete compliance (e.g. incomplete manuals) Exceeds requirement citations (E) • recognize those situations where a PFD facility exceeds the intent of the standard and employs commendable practice the intent of capturing these occurrences is to promote and focus on quality initiatives
18.	AC On-site	Notify AC/CPSA immediately of any serious deficiencies that may have immediate impact on staff or patient safety	Assessors encountering any situation that in their judgment, represents potential for significant immediate harm to staff or patients are directed to bring it to the attention of: #1 - the pulmonary function diagnostics personnel for immediate action as deemed appropriate #2 - AC who will consult with CPSA immediately via telephone

Responsibility		Task	Additional Information

19.	AC
	On-site
		Conduct a summation conference for the PFD facility management and personnel	The primary purpose of the summation conference is to highlight the key findings and outline the next steps in the assessment process.
			The AC serves as the primary spokespersons during the summation meeting in order to bring consistency of format and detail to the process.
			In person summation conferences are conducted at each facility at the end of the facility assessment.
			Summation conference agenda:
			• Short review of the objectives of the accreditation process
			• Review of commendable findings and practices including any 'E' citations
			• Review of significant non-conformances. (The purpose of this is to ensure that there are no "significant surprises" in the report when received by the facility/zone.)
			• Review of purpose and inclusion of interview findings in final reports
			• Overview of the next steps in CPSA accreditation process including timelines for:
			  ○ meeting of the ACPFD to review the draft final report
			  ○ distribution of final report
			  ○ PFD facility responses and submission of EOC
			• Acknowledgement of PFD facility personnel for their cooperation and support of the accreditation process.

20.	AC	Request sampling of interpreted reports for independent review	A random sampling of 10 charts from the previous three months of testing done at the facility should be requested. The charts should represent the case mix of the population served by the lab. Preference is for secured electronic submission of associated reports/paperwork, etc. The PFD facility will be asked to upload the chosen examinations into the electronic portal. Same day upload is optimal. The PFD facility will have 5 business days from the date of the on-site assessment to provide the documentation. The PFD facility will notify CPSA when the reports are ready for review. Examinations and associated reports/paperwork that can be taken away by the AC on the same day.

Responsibility		Task	Additional Information
21.	AC	Uploads findings to SharePoint in a citation report	Within 7 days following the assessment the AC will upload their audit findings along with any photographs, sample documents, etc. to the SharePoint site.

4.4 POST ASSESSMENT

Responsibility		Task	Additional Information
22.	CPSA (Accreditation Assistant)	Creates draft assessment report.	
23.	CPSA (Program Manager)	Reviews assessment reports	Standardizes citation language and assigns requirements, Evidence of Compliance (EOC) required and timeline for submission of EOC.
24.	CPSA (Physician reviewer)	Physician reviewer reviews reports to ensure ATS criteria for interpretation are being met	The PR will have one business week to review the reports and associated paperwork and submit findings back to CPSA via SharePoint.
25.	CPSA (Program Manager)	Reviews physician reports	If required citations are added to the assessment report if necessary from the review of the chart report. 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.
26.	CPSA (Quality System Coordinator)	Reviews assessment facility report	Reviews/revises/ approves the facility assessment citations to: • eliminate any personal bias • ensure consistent application of the standards from one assessor/assessment to another • endorse EOC requirement • ensure standards/requirements reflect current best practice

Responsibility		Task	Additional Information
27.	CPSA (Accreditation Assistant)	Loads the assessment report into the facility's folder on SharePoint, notifies the facility the report is available	
28.	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.
29.	CPSA (Program Manager)	Reviews facility responses to requirements, recommendations and requested evidence of compliance.	CPSA reviews the facility responses to the requirements, recommendations and requested evidence of compliance and provides recommendations to MFACP as to the appropriateness of the response. CPSA reviews the assessment team feedback for consistency prior to MFAC review.
30.	CPSA (Quality System Coordinator)	Reviews responses to assessment report	Reviews the PM's review and comments 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
31.	CPSA (MFAC)	Grants full accreditation status.	Once the identified "provisional" non-conformance(s) are satisfactorily addressed, the facility is granted "Full Accreditation" status by Medical Facility Accreditation Committee (MFAC). A certificate is issued once approval has been given by MFAC. If a laboratory is denied accreditation, the laboratory may access CPSA's formal appeal process.

Responsibility		Task	Additional Information
32.	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 Annual/Assessment Fees

Annual Fees

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

Assessment Fees

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