cpsa
COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

Accreditation Program Guide

Psychedelic-Assisted Psychotherapy: New Facility

Version 1.0
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1 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.

1.1 BENEFITS OF THE CPSA PSYCHEDELIC-ASSISTED PSYCHOTHERAPY PROGRAM

- assists facilities with the process of ensuring accuracy and reliability of services,
- provides standards of practice and assesses compliance to the standards,
- identifies deficiencies that affect the quality of 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 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, and
- ensures effective medical direction over medical practices so that business interests do not determine the standard of care.

1.2 AUTHORITY AND OVERSIGHT

Facilities that provide psychedelic-assisted psychotherapy (PAPT) are required to be accredited by CPSA as per the *Mental Health Services Protection Act* and *Regulation*.

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

Pursuant to section, 8.4 of Schedule 21 of the *Health Professions Act*, and the Bylaws of CPSA, PAPT 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 PAPT providing copies of the same if requested;

c) provide the information described in clause (c) in the form requested by the Assessment Team;

d) provide requested samples or copies of any material or product originating from PAPT for the facility;

e) answer questions posed by the Assessment Team as to procedures or standards of performance and if requested, providing copies of records relating to procedures followed and standards of performance applied in the facility; and

f) providing requested copies of all documents and information relating to business arrangements involving the practice conducted in the Psychedelic-Assisted Psychotherapy facility.

A standing committee, the Medical Facility Accreditation Committee (MFAC), oversees CPSA's accreditation programs with members appointed by Council from diverse disciplines in clinical and diagnostic medicine.

1.3 OVERVIEW OF PSYCHEDELIC-ASSISTED PSYCHOTHERAPY PROGRAM

CPSA administers accreditation programs for those services that the CPSA Council determines deserve explicit standards and verification of compliance with those standards.

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 quality, safety and reliability of the service being provided, as well as the performance of the people involved, and the service produced.

The Accreditation Program examines all aspects of service quality and operations, including:

- organization, management and personnel,
- quality management systems including policy, process and procedure creation and maintenance,
- physical facilities,
- equipment, supplies, consumables (including pharmaceuticals),
- information systems and record storage,
- pre-therapy, therapy and post-therapy activities,
- quality assurance activities,
- safety, and
- infection prevention and control.

The Psychedelic-Assisted Psychotherapy (PAPT) Accreditation Program is a peer review process with a goal to improve 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.

PAPT facility accreditation is a process-based audit model; it is not possible to directly access every individual standard for the entire scope of service provision.

1.3.1 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 the release of assessment findings or accreditation certificates to other parties.

1.3.2 Frequency and Selection of Facilities to be Assessed

Facilities are assessed initially when opened, subsequently on a 4-year rotation or if the facility is relocated to a different physical location. This does not preclude an interim assessment that may be required as a result of expansion of services or an unsatisfactory performance complaint.

After a new facility is registered and initially accredited, it will then be added in to the regular 4-year cycle.

1.3.3 On-going Self-Assessment

CPSA accreditation general standards require facilities to conduct formal internal audits of all system elements, both managerial and technical, at a frequency defined in their quality management system. Facilities are not required to submit self-audit findings to CPSA.

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

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

1.4 ASSESSMENT TEAMS

1.4.1 Assessment Coordinator

Assessment Coordinators (ACs) are consultants of CPSA. All ACs participate in CPSA training sessions before being allowed to perform any on-site assessments.

During the assessment, ACs 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.

1.4.2 Physician Reviewer

A Physician Reviewer will be assigned to an assessment team to perform chart reviews.

1.4.3 Conflict of Interest/Vaccination Status/Confidentiality Agreements/Liability

All members of the CPSA accreditation committees and assessment teams sign a confidentiality agreement with CPSA annually. Committee members, Assessment Coordinators and Physician Reviewers are also required to confidentially destroy all assessment materials or return to CPSA for confidential disposal.

2 Standards Document

2.1 STANDARDS OVERVIEW

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

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

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

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

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

All accredited PAPT facilities receive a complete standards document. 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, the standards documents applicable to the scope of the services provided by a PAPT facility will be made available to:

- The facility 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

2.2 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.

Example: Standards Document Format - Figure 2

#	Standard	Reference	Assessment of Compliance
PAPT.6.2 Pre-Service – Patient Preparation, Screening & Consent			
PAPT.6.2.1 **PS**	There are policies, processes, procedures and criteria for review and acceptance / rejection of patients and/or requested PAPT treatment services.	ISQua1 – 4.3, 5.1, 5.3, 5.10 5.11 For authorized requestors refer to Appendix A.3	Are requisitions received from authorized requestors? Are there patient preparation and pre-screening protocols that are appropriate for the psychedelic drugs and range and complexity of the psychotherapy treatments offered in the facility? Are patients provided with verbal and written instructions for preparing for treatments, where necessary? Does the facility have a policy requiring patients to complete a comprehensive pre-screening form where applicable? Does the facility have policy, process and procedure that define inclusion and exclusion criteria? Does the facility have defined absolute / relative rejection criteria and a process to address them? Is there evidence that patients are being pre-screened as required?
			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.
  - Non-compliance with standards with either a patient safety (PS) or staff safety (SS) 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)** that are listed 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)

2.3 ASSESSMENT OF COMPLIANCE

- Although the Assessment of Compliance (AOC) questions address the key evidence required to meet the intent of each standard, **they are not meant to be all-encompassing**.
- There may be other evidence that demonstrates compliance with the intent of the standard. Individual assessors apply their own expertise in determining compliance with each standard.
- Compliance with the standard may be assessed by review of documents and records, observation, interviews or a combination of these techniques.
- Where AOCs state "All of the following", compliance with all elements is expected to achieve compliance with the standard.
- The standards are process-based and a single non-compliance may encompass one or more observations. In assessing compliance with the standard, assessors will record direct specific objective evidence, which will be included in the report for each non-compliance.

Assessment of Compliance Categories

Compliance Assessment Category:	
C	compliant, 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

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

P - "In Progress" citations require submission of future evidence of compliance based on direction from the assessor and/or the Advisory Committee. Examples include

situations such as equipment has been purchased but not on-site and/or implemented; renovations in progress but not completed.

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

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

2.4 TERMS AND DEFINITIONS

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

2.5 REFERENCE LISTING

A detailed reference listing is provided at the end of this document. The references support the content and intent of each standard. It should be noted that all components of the cited references might not always be relevant and/or applicable. Compliance is expected with CPSA Standards not the cited references.

2.6 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 (located at end of Standards document)
- 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 like services across the province and are not limited to an organization specific practice
- contact information included for use by CPSA if clarification of submission is required

3 Accreditation Process – New Facilities

3.1 PHASE 1

	Responsibility	Task	Additional Information
1.	Facility	Facility applies to be accredited on the CPSA website	Apply at https://cpsa.ca/facilities-clinics/accreditation/psychedelic-assisted-psychotherapy/register-a-new-facility/
2.	CPSA	Processes the application and charges registration fee	
3.	CPSA	Contact is made with the Medical Director	The Assessment Logistics Form (ALF) is sent directly to the Medical Director. The form asks them to identify a key assessment facility contact.
4.	Facility	Completes ALF Form	Completed form is submitted to CPSA.

5.	CPSA	Provides SharePoint access	CPSA sets up secure facility access to the CPSA SharePoint site for the Medical Director and key facility assessment contacts identified in the ALF form.
			CPSA provides the following information on the SharePoint Site:
			• program guide to review
			• PAPT Accreditation Standards
			• PAPT facility training sessions that focus on:
			  • overview of assessment process steps
			  • use of the standards tool
			  • assessment day expectations
			  • assessment logistics & timelines

	3.1.1 PRE-ASSESSMENT		
6.	CPSA	Selects assessment team members and forwards a Team Approval Form to the facility	Selection of the Assessment Team is based on: • scope and complexity of services being provided • experience of Team members • mitigation of any conflict of interest
7.	PAPT facility Medical Director	Reviews and approves the Team Approval Form	

	Responsibility	Task	Additional Information
8.	CPSA	Provides via SharePoint a "*Pre-assessment Data Verification" (PADV) Form*	CPSA uploads a copy of the form into the SharePoint facility folder. The PADV requests submission of the following for each individual facility undergoing assessment: • general facility information • hours of operation • key facility personnel • scope of modalities (services) • organizational structure • blank examples of facility examination request (requisitions/consultation) forms and blank screening form/questionnaires)
9.	PAPT Facility	Completes and uploads *PADV* form and requested documents to SharePoint site	CPSA reviews the PADV form for completeness.
10.	CPSA	Reviews submitted forms and assessment documentation and notifies the AC that the materials are complete and ready to be reviewed	Ensures completed forms and submitted documentation (embedded and uploaded on SharePoint) are complete and readable
11.	CPSA Assessment Coordinator (AC)	Performs the hybrid desk audit portion of the assessment	The AC reviews the completed PADV form, submitted documentation (embedded and uploaded on SharePoint), and prepares an initial citation report, noting identified areas of concern for further follow-up during the assessment. Records the following for each citation in the citation report template: • standard number • compliance assessment category (CPEN) • detailed observation/objective evidence • comments (where applicable)
12.	AC	Determines assessment date in consultation with the facility	Assessments are not scheduled until all assessment documentation is reviewed. AC notifies CPSA of the on-site assessment date.

	Responsibility	Task	Additional Information
13.	CPSA	Sends confirmation of assessment date to AC and facility	
	3.1.2 On-Site Assessment		
14.	AC On-site	Conduct an opening meeting with facility personnel	At the beginning of the on-site assessment at each facility, the AC conducts an opening meeting for facility personnel that encompasses: • introductions • assessment logistics and timelines • assessment process outline
15.	PAPT facility	Conducts facility tours for AC	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	The accreditation assessment process involves: • verifying compliance with the intent of accreditation standards • follow-up of previously identified areas of concern • interaction with staff **CPSA Assessment Tool:** The on-site assessment is performed using the facility specific standards document tools. **Assessment of Compliance** Compliance with the applicable standard may be assessed by review of documents and records, observation, interview or a combination of these techniques. Focus is on • directly assessing ALL applicable standards with either a PS or SS designation • reviewing documents (policies, processes and procedures - PPPs) and records
17.	AC On-site	Notify CPSA immediately of any serious deficiencies that may have immediate impact on staff or patient safety	ACs encountering any situation that in their judgment, represents potential for significant immediate harm to staff or patients are directed to bring it to the attention of: 1. The PAPT facility personnel for immediate action as deemed appropriate.

	Responsibility	Task	Additional Information
			2. AC will consult with CPSA immediately via telephone. CPSA Critical Findings policy, process and procedures will be followed, if necessary.
18.	AC On-site	Conduct a summation conference for the PAPT facility management and personnel	The primary purpose of the summation conference is to highlight the key findings and outline the next steps in the assessment process. In person summation conferences are conducted at each facility at the end of the facility assessment. Summation conference agenda: • short review of the objectives of the accreditation process • review of commendable findings and practices including any 'E' citations • review of significant non-conformances. (The purpose of this is to ensure that there are no "significant surprises" in the report when received by the facility.) • respond to any facility questions
19.	CPSA	Communicates decision on commencement of service provision to the facility	Based on communication received from the AC, the Program Manager determines whether the facility can commence service provision. The facility receives an immediate, formal electronic communication indicating: • approval for commencement of service provision (Provisional accreditation status) OR • the requirement for resolution of identified significant non-conformances. Upon resolution of the identified significant non-conformances, CPSA communicates the approval for commencement of service provision (Provisional accreditation status)
20.	AC	Uploads citation report to SharePoint	Following the assessment the AC will upload their citation report along with any photographs, sample documents, etc. to the SharePoint site.
21.	CPSA	Prepares assessment report	Creates the Phase 1 facility assessment report
22.	CPSA (PM)	Vets and approves assessment Phase 1 facility report	Reviews/revises/ approves the facility assessment citations to:

	Responsibility	Task	Additional Information
			• ensure consistent application of the standards from one assessor/assessment to another • ensure requirements reflect current best practice
23.	CPSA Accreditation & Quality Systems Coordinator (AQSC)	Reviews the assessment report	Reviews/revises the PAPT facility assessment report 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 requirements reflect current best practice
24.	CPSA	Loads the assessment report into the facility's report folder on SharePoint, notifies the facility the report is available	Within 15-20 business days of the ASQC review CPSA posts the finalized individual facility report in the facility's folder on the SharePoint site. CPSA notifies the facility Medical Director and facility Accreditation contact that the final report is available.
25.	Facility	If applicable, the facility submits a response to requirements and/or recommendations requested with evidence of compliance.	The final report is formatted to include a section for a facility response to each individual citation. 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 facility's folder on the 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.
26.	CPSA (PM)	Reviews facility responses to requirements, recommendations and requested	CPSA reviews the facility responses to the requirements, recommendations, requested evidence of compliance, and provides recommendations to MFAC as to the appropriateness of the response.

	Responsibility	Task	Additional Information
		evidence of compliance.	
27.	CPSA (AQSC)	Reviews/approves facility responses.	Reviews the responses to EOC and 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
28.	CPSA	Informs facility they have completed Phase 1	When all citations have been responded to in an acceptable resolution the facility is informed they have completed Phase 1 of the process
3.2 PHASE 2			
29.	CPSA	Request sampling of patient charts for independent review	A random sampling of 10 charts from prescribed health services provided at the facility will be requested 6-8 weeks after the facility has satisfactorily answered all the citations from the Phase 1 report. The charts should represent the case mix of the population served by the facility. The PAPT facility will be asked to upload the charts into the facility's folder on the SharePoint site. The PAPT facility will notify CPSA when the charts are ready for review.
30.	CPSA (Physician reviewer)	Physician reviewer reviews charts	The PR will review the referral forms, charts, associated paperwork, and submit findings back to CPSA via the SharePoint site. The chart review is not meant to assess individual specialist competency; it is rather a benchmark of quality services and processes.
31.	CPSA	Reviews physician report	

32.	CPSA	Prepares any additional citations based on the physician reviewer report	Based on the physician reviewer report, CPSA may create additional citations and add them to the facility report:
			• Citations:
			  • standard number
			  • safety Risk category

	Responsibility	Task	Additional Information
			• compliance assessment category (PEN) • detailed observation / objective evidence • requirement • evidence of compliance (where applicable) • timeline for submission of EOC
33.	CPSA	Loads the report into the facility's report folder on SharePoint, notifies the facility the report is available	CPSA notifies the facility Medical Director and facility Accreditation contact that the updated report is available in facility's folder on the SharePoint site.
34.	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 facility's folder on the SharePoint site. For requirements with requests for EOC, facilities must provide a response and any required EOC within 30 days from the date of the updated report.
35.	CPSA	Reviews facility responses to requirements, recommendations and requested evidence of compliance.	Reviews the responses
36.	CPSA (AQSC)	Reviews/approves facility responses	Reviews the responses to EOC and CPSA evaluation to: • eliminate any personal bias • ensure consistent application of the standards • endorse any further EOC requirements and timeline for submission based on risk assessment
37.	CPSA (MFAC)	Grants full accreditation status	Accreditation decisions are reviewed and approved by MFAC. If a facility is denied accreditation, the facility may access CPSA formal appeal process.

	Responsibility	Task	Additional Information
38.	CPSA	Provides Certificate of Accreditation and Window Vinyl to display at facility	
39.	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 CPSA. Changes to process are implemented as appropriate based on feedback.

4 Fees

4.1 ANNUAL FEES

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

4.2 ASSESSMENT FEES

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