COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

Diagnostic Accreditation Program

ACCREDITATION STANDARDS

Community Neurodiagnostics

Diagnostic Accreditation Program
College of Physicians and Surgeons of British Columbia
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Diagnostic Accreditation Program

Established in 1971, the Diagnostic Accreditation Program (DAP) has a mandate to assess the quality of diagnostic services in the province of British Columbia through accreditation activities. As a program of the College of Physicians and Surgeons of British Columbia, the mandate and authority of the DAP is derived from section 5 of the College Bylaws under the *Health Professions Act,* RSBC 1996, c.183.

The DAP is committed to promoting excellence in diagnostic health care through the following activities:

- establishing performance standards that are consistent with professional knowledge to ensure the delivery of safe, high quality diagnostic service
- evaluating a diagnostic service's level of actual performance to achieving the performance standards
- establishing a comparative database of health-care organizations, and their performance to selected structure, process, and outcome standards or criteria
- monitoring the performance of organizations through the establishment of external proficiency testing programs and other robust quality indicators of performance
- providing education to health-care organizations, managers, and health professionals on quality improvement strategies and best practices in diagnostic health care
- ensuring information learned from accreditation processes is used for system wide improvement
- reporting to government, stakeholders and the public on the performance of the diagnostic health-care system as assessed through accreditation
- strengthening the public's confidence in the quality of diagnostic health care
- assisting organizations to reduce risks and increase safety for patients and staff
- assisting organizations to reduce health-care costs by promoting quality practices that increase efficiency and effectiveness of services
- serving and safeguarding the public

The Diagnostic Accreditation Program currently has 23 accreditation programs covering the following diagnostic services:

Diagnostic imaging

- diagnostic radiology
- diagnostic mammography
- diagnostic ultrasound
- diagnostic echocardiography
- diagnostic computed tomography
- diagnostic magnetic resonance imaging
- diagnostic nuclear medicine
- diagnostic bone densitometry

Laboratory medicine

- anatomic pathology
- chemistry
- cytogenetics
- cytology
- hematology
- microbiology
- molecular diagnostics
- point-of-care testing
- transfusion medicine

Neurodiagnostic services

- electroencephalography
- evoked potentials
- electromyography and nerve conduction studies
- hospital-based services
- community-based services

Pulmonary function

- hospital-based services
- community-based services

Polysomnography

- hospital-based services
- community-based services

Accreditation standards

The foundation of the accreditation programs are the provincial standards and accompanying criteria set by the Diagnostic Accreditation Program. These are evidence-based, outcome-focused mandatory requirements and best practices that are aligned to the principles of quality. The standards and criteria are directive in nature yet allow the diagnostic service flexibility in how they approach and address each element. The accreditation standards are directive, deliverable statements. The accompanying criteria specify the activities that must be completed to achieve the standard.

Standards

- Outcome focused
- Directed at the operational level
- Directive not prescriptive

Criteria

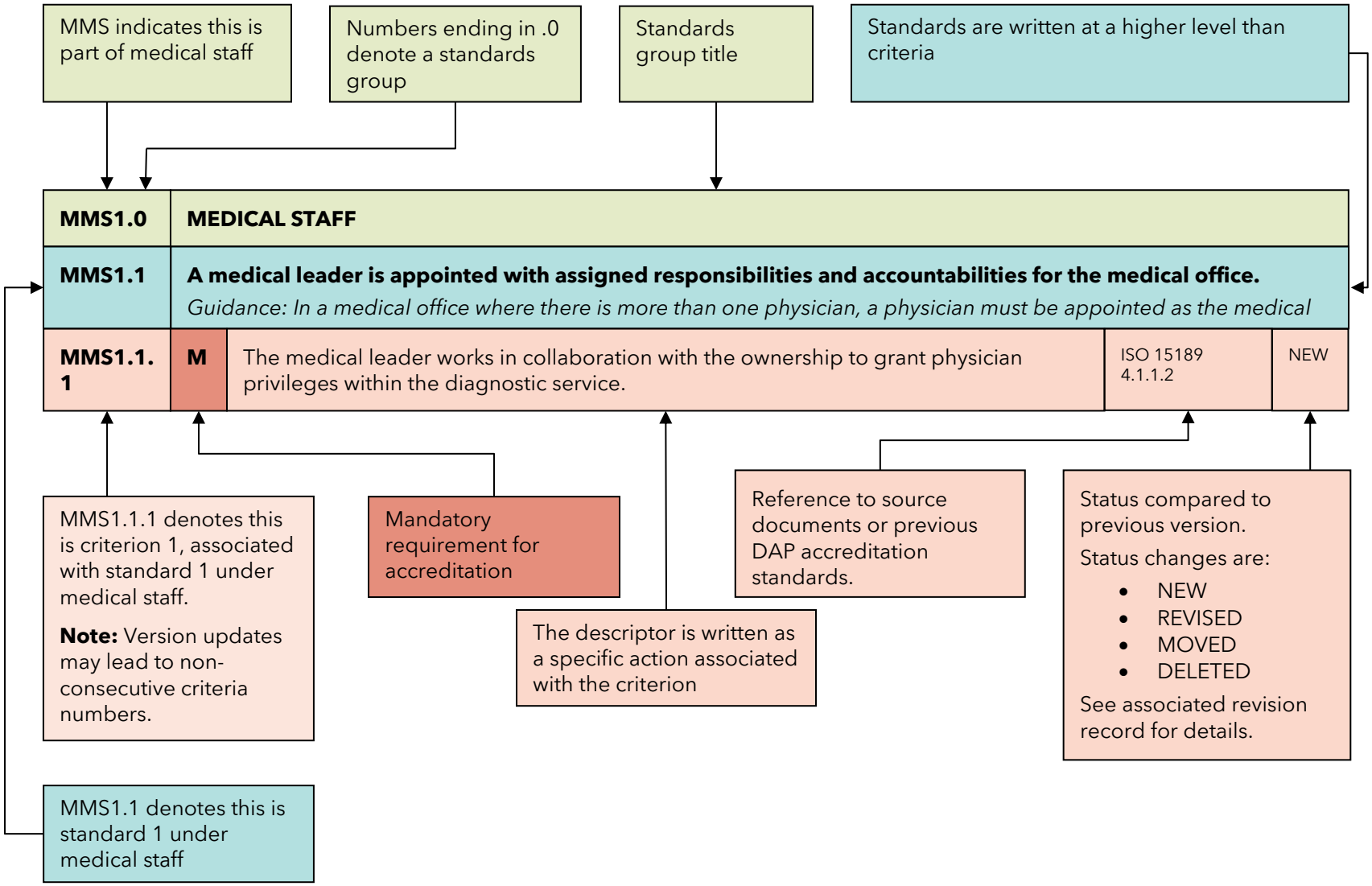
- Specify activities to be completed
- Lead to standard attainment

The Diagnostic Accreditation Program's accreditation standards are developed through a collaborative, consultative and consensus building process that involves health professionals and organizations, academics, experts, consumers, health authorities, colleges and the Ministry of Health. The process for standards development and review allows for considerable input from the diagnostic services that will be using the standards.

The DAP accreditation standards consist of three components:

1. **Standards group**– A standards group is identified as a whole number with header (e.g. 1.0 Medical Staff).
2. **Standard** – A statement that contains one or more related specific criteria. A standard is identified by a two-digit number indicating the standards group that it is associated to, and a second level identifier (e.g. 1.1).
3. **Criteria**– Specific actions for each standard, criterion are identified by three digits (e.g. 1.1.1). A criterion is either a mandatory requirement for accreditation, or a best practice. Mandatory criteria are indicated by a bold type face **M**.

Example of an accreditation standard



Leadership

Each medical office has a leadership structure that is ultimately responsible for the quality and safety of services provided. For privately owned facilities the structure may be a partnership group or an individual as the sole proprietor. Many leadership responsibilities directly affect the provision of diagnostic services as well as the day to day operations of the medical office.

No.		Description	Reference	Change
MLP1.0		**ACCOUNTABILITY AND RESPONSIBILITY**		
MLP1.1		**Accountability and responsibility is assigned for key leadership functions.**		
MLP1.1.1	**M**	A medical leader is appointed responsibility for the quality and safety of the medical practice within a diagnostic service.	DAP V1.1	
MLP1.1.2	**M**	Individuals are appointed with responsibility for the quality and safety of operational processes and technical operations within the diagnostic service. *Guidance: In single physician offices, this individual may be the medical leader.*	DAP V1.1	

Medical staff

Credentialing and privileging

Credentialing is a process that involves the collection, verification and assessment of information regarding the education, training, experience and ability of an individual physician to perform a requested privilege. In British Columbia physicians must have the requisite credentials as outlined in the Provincial Privileging Dictionaries. Refer to http://bcmqi.ca/privileging-dictionaries.

Credentialing for physicians who hold privileges at any health authority facility is performed by the health authority, and includes assessing eligibility for Medical Services Plan (MSP) billings for restricted services. Many medical offices are owner operated solo practices and the physician may not hold privileges with a health authority; therefore, the physician would not have proceeded through a credentialing process. In these instances the physician is licensed to their scope of practice through the College of Physicians and Surgeons of BC. For MSP billing purposes for a restricted diagnostic service, the College will review the associated credentials required to be eligible to bill for these services and will notify MSP of the eligibility. For further information please contact credentialing@cpsbc.ca.

For community-based multi-physician facilities the medical director and ownership are responsible to ensure the physicians that practice in their facilities are appropriately credentialed, either through the health authority or by reviewing the credentials of the physician and ensuring that the physician has been deemed eligible to bill MSP for the services. There must be a formal process used for credentialing and privileging, and it is the expectation of these accreditation standards that the medical director and ownership can demonstrate these processes.

No.	Description	Reference	Change
MMS1.0	**MEDICAL STAFF**		
MMS1.1	**A medical leader is appointed with assigned responsibilities and accountabilities for the medical office.** *Guidance: In a medical office where there is more than one physician, a physician must be appointed as the medical leader. If a physician is the owner in a solo practice, they are responsible for ensuring the activities of medical leadership take place, inclusive of ensuring that they are qualified and competent themselves to undertake the scope of medical service provided within their medical office.* *For community-based multi-physician facilities the medical leader and ownership are responsible to ensure the physicians that practice in their facilities are appropriately credentialed, either through the Health Authority or by reviewing the credentials of the physician and ensuring that the physician has been deemed eligible to bill MSP for the services.*		
MMS1.1.1	**M** The medical leader works in collaboration with the ownership to grant physician privileges within the diagnostic service.	DAP V1.1	

No.	Description	Reference	Change
MMS1.1.2	**M** The medical leader continuously monitors the professional performance of medical staff practicing in the diagnostic service through a peer review process. *Guidance: All physicians working in the diagnostic service must participate in a medical peer review process.*	DAP V1.1	
MMS1.2	**Information for each medical practitioner is collected, verified and assessed relative to the requested scope of practice.**		
MMS1.2.1	**M** The medical office confirms physician licensure from the College of Physicians and Surgeons of British Columbia annually. *Guidance: Physician licensure can be confirmed through the College of Physicians and Surgeons of British Columbia website: https://www.cpsbc.ca/physician_search.*	CPSBC	
MMS1.2.2	**M** The medical office maintains records of physician MSP billing eligibility confirmation from the College of Physicians and Surgeons of British Columbia to bill for restricted services, if not affiliated with a health authority.	DAP V1.1	
MMS1.2.3	**M** The medical office maintains records of each physician's current experience and practice to perform their scope of service. *Guidance: Refer to http://bcmqi.ca/privileging-dictionaries/ for the number of examinations required for renewal of privileges.*	BCMQI	
MMS1.3	**Electromyography (EMG) services are provided by qualified and competent physicians.**		
MMS1.3.1	**M** Physicians providing diagnostic EMG services have the requisite credentials for privileges as outlined in the Provincial Privileging Dictionaries. *Guidance: EMG services are not considered core privileges and therefore require further training, experience and demonstrated skills. Refer to http://bcmqi.ca/privileging-dictionaries/.*	BCMQI	
MMS1.4	**Nerve conduction studies (NCS) services are provided by qualified and competent physicians.**		
MMS1.4.1	**M** Physicians providing diagnostic NCS services have the requisite credentials for privileges as outlined in the Provincial Privileging Dictionaries. *Guidance: NCS services are not considered core privileges and therefore require further training, experience and demonstrated skills. Refer to http://bcmqi.ca/privileging-dictionaries/.*	BCMQI	

No.		Description	Reference	Change
MMS2.0		**DELEGATED MEDICAL ACTS**		
MMS2.1		**Delegated medical acts are clearly defined.** *Note: A delegation occurs when a physician authorizes another person to perform a medical act who is not authorized to do so as part of a regulated health professional scope of practice. It is an important point that technologists/technicians/diagnostic professionals in diagnostic services assessed by the DAP do not at this time have a professional college and are not regulated health professions under the Health Professions Act. Although diagnostic professionals are well trained and have a well-defined scope of practice they cannot perform any act that is considered the practice of medicine without that act being delegated to them by a physician with a license in BC. The delegation of a medical procedure is an important act because of the possible safety implications for patients. Delegated medical acts should be carefully considered with respect to patient safety and organizational risk. If a medical act can be delegated with appropriate training and oversight so as to ensure patient safety, then the ownership/leadership of the facility must further evaluate organizational risk before approving the undertaking. The DAP considers prescribing and administering drugs, and performing any invasive procedure as examples of medical acts.*		
MMS2.1.1	**M**	Each delegated medical act is clearly defined and circumscribed.	DAP V1.1	
MMS2.1.2	**M**	The degree of medical supervision required is identified for each delegated medical act. *Guidance: Medical supervision may be direct, with the physician in attendance, or through technology (e.g. video link, telephone).*	DAPV1.1	
MMS2.1.3	**M**	Competency requirements to perform the delegated medical act are clearly identified.	DAP V1.1	
MMS2.2		**The delegation of medical acts has been approved and accepted.**		
MMS2.2.1	**M**	There is consensus from the medical community that the delegation of the medical act is appropriate.	DAP V1.1	
MMS2.2.2	**M**	The delegation of the medical act has been accepted by the individual(s) who will perform the delegated medical act.	DAP V1.1	
MMS2.2.3	**M**	Agreement from the governing body/ownership of the organization has been obtained prior to the delegated medical act being carried out in the organization.	DAP V1.1	
MMS2.3		**Delegated medical acts are performed by competent individuals.**		
MMS2.3.1	**M**	Additional training is provided to individuals performing the delegated medical act.	DAP V1.1	

No.	Description		Reference	Change
MMS2.3.2	**M**	Competency assessment to perform a specific delegated medical act is conducted by a physician or technical delegate. *Guidance: The competency assessment of the technical delegate is conducted by a physician with relevant expertise in the medical act.*	DAP V1.1	
MMS2.3.3	**M**	Delegated medical act competency assessment records include the name of the individual.	DAP V1.1	
MMS2.3.4	**M**	Delegated medical act competency assessment records include the date of the assessment.	DAP V1.1	
MMS2.3.5	**M**	Delegated medical act competency assessment records include the specific act(s) being assessed.	DAP V1.1	
MMS2.3.6	**M**	Delegated medical act competency assessment records include the name of the physician or technical delegate conducting the assessment.	DAP V1.1	
MMS2.3.7	**M**	Delegated medical act competency assessment records include the signature of the physician attesting to the competence of the individual performing the specific act(s).	DAP V1.1	
MMS2.3.8	**M**	The record of assessment of competency for each individual performing the specific act(s) is reassessed annually by a physician or technical delegate.	DAP V1.1	

Human resources

The medical office must have methods in place to ensure that staff are managed as effectively as possible, since the quality of care and services provided within the medical office will be greatly affected by the quality of the staff working there.

No.		Description	Reference	Change
MHR1.0		**HUMAN RESOURCES**		
MHR1.1		**The staff and physicians understand their roles and accountabilities.**		
MHR1.1.1	**M**	Job descriptions are available for all staff that reflect current practice, certification or registration and position responsibilities.		
MHR1.1.2	**M**	Criminal record checks are performed for staff members that work with or may have unsupervised access to children or vulnerable adults. *Reference: Criminal Records Review Act* *http://www.bclaws.ca/Recon/document/ID/freeside/00_96086_01*	ISO 15189 5.1.9 k	
MHR1.1.3	**M**	Human resource records are kept for all staff and are maintained in a confidential manner.		
MHR1.2		**The medical office has qualified and competent staff to deliver services.**		
MHR1.2.1	**M**	The medical office selects and recruits administrative and technical staff based on qualifications and experience (e.g. certification, knowledge, skills and reference checks).		
MHR1.2.2	**M**	Technologists providing EMG/NCS services are certified by and/or are eligible to write the certification examination from the Board of Registration of Electromyography Technologists of Canada (B.R.E.T.C.), or the American Board of Electrodiagnostic Medicine (ABEM), or the American Association of Electrodiagnostic Technologists (AAET).	BRETC ABEM AAET	
MHR1.2.3	**M**	Technical staff providing EMG/NCS services are graduates of an accredited training school for neurodiagnostics and/or are enrolled in a technical training program by a physician qualified to perform EMG/NCS services based on the Provincial Privileging Dictionary.		
MHR1.2.4	**M**	There is a documented process for technologists providing neurodiagnostic services that are eligible for certification to become certified in a defined period.		NEW

No.		Description	Reference	Change
MHR1.3		**Orientation and training for the safe provision of quality diagnostic services are provided.** *Intent: Staff training is an ongoing quality improvement initiative.*		
		Staff receive orientation and training to address:	ISO 15189 5.1.9	
MHR1.3.1	**M**	• adverse events and critical incident reporting		
MHR1.3.2		• patient identification		
MHR1.3.3	**M**	• sharps handling and disposal		
MHR1.3.4	**M**	• WHMIS (e.g. appropriate disposal of solutions and supplies)		
MHR1.3.5	**M**	• staff injury reporting		
MHR1.3.6	**M**	• fire safety procedures *Guidance: Staff are aware of the location of firefighting equipment and actions taken when a fire occurs.*		
MHR1.3.7	**M**	• management of aggressive behavior		
MHR1.3.8	**M**	• medical emergency procedures (e.g. cardiac arrest)		
MHR1.3.9	**M**	• information management systems		
MHR1.3.10	**M**	• confidentiality of data and information		
MHR1.3.11	**M**	• infection prevention and control (e.g. hand washing, blood and body fluid exposure, proper use of PPE)		
MHR1.4		**The competency of technical staff is assessed.**		
MHR1.4.1	**M**	Competency assessments are documented and performed to evaluate the knowledge, skills and abilities of the staff to ensure they are proficient in performing their duties.	DAP V1.1	REVISED
MHR1.4.2	**M**	Competency assessments occur at defined intervals. *Intent: The diagnostic service defines the appropriate interval for competency assessments and documentation of the assessment is maintained.*	DAP V1.1	
MHR1.4.3	**M**	A documented action plan is developed when a staff member's competence does not meet expectations.	DAP V1.1	REVISED
MHR1.5		**Individual staff members receive performance feedback.**		

No.	Description	Reference	Change
MHR1.5.1	**M** Performance appraisals are regularly conducted and are based on job responsibilities and expectations. *Guidance: The medical office must define the frequency of staff performance appraisals; however, the office is strongly encouraged to conduct appraisals every one to two years. The results of competency assessments are to be reviewed as part of the performance appraisal.*	DAP V1.1	
MHR1.6	**Staff are supported and provided with ongoing education, training and professional development.**		
MHR1.6.1	Professional development and continuing education is encouraged and supported.		
MHR1.6.2	Staff participate in ongoing education, training and professional development to meet the needs of the diagnostic service.		

Patient and client focus

Engaging and involving patients in their health care ensures their needs are met in a safe and effective manner. A patient and client focused culture enables the medical office to be more responsive and enhances the quality and safety of the care and services provided to patients and clients.

The patient and client focus standards examine patient and client-centered services including how the diagnostic service determines the requirements, expectations and preferences of patients and clients. Examples of clients may include referring physicians, WorkSafeBC, and insurance companies.

No.		Description	Reference	Change
MPC1.0		**PATIENT AND CLIENT FOCUS**		
MPC1.1		**Service standards of the medical office are defined and communicated to patients and clients.**		
MPC1.1.1		The time from referral to the test/consultation is monitored.		
MPC1.1.2		Turnaround times for reports are monitored. *Guidance: Turnaround times are established for all aspects of the reporting process including testing/consultation completion, dictation, transcription and distribution of the final report.*		
MPC1.2		**Interpreting physicians are responsive to patient and physician inquiries.**		
MPC1.2.1	**M**	Interpreting physicians are responsive to case specific or procedural inquiries.		
MPC1.3		**Patients are involved in decision making about their care and procedure(s).**		
MPC1.3.1	**M**	Patients are provided with information about their procedures so that they can participate in making informed decisions.		

General safety

The general safety accreditation standards include those most common to a medical office; however, they do not encompass all of the requirements under the *Workers Compensation Act* of British Columbia. Physicians and staff are encouraged to review section 115 of this Act and the associated occupational health and safety regulations to ensure they are meeting all regulatory requirements in British Columbia.

Questions specific to the act and the associated occupational health and safety regulations should be directed to WorkSafeBC for interpretation, advice and direction.

No.		Description	Reference	Change
MGS1.0		**GENERAL SAFETY**		
MGS1.1		**Potential hazards and risks to staff, patients and visitors are minimized.**		
MGS1.1.1	**M**	Safety issues are discussed and monitored. *Guidance: For small organizations with less than 20 employees, the employer must initiate and maintain a less formal program based on regular monthly meetings with workers for discussion of health and safety matters.* *Reference: https://www.worksafebc.com/en/law-policy/occupational-health-safety/searchable-ohs-regulation/ohs-regulation/part-03-rights-and-responsibilities*	WorkSafeBC	
MGS1.1.2	**M**	Regular inspections of the work area, equipment, and practices are performed at a defined interval to identify and resolve safety hazards. *Guidance: Occupational health and safety regulations require safety audits/inspections to be conducted. A risk assessment should be performed to determine the interval of the assessment.*		
MGS1.1.3	**M**	Safety concerns are addressed immediately.		
MGS1.1.4	**M**	There is a basic first aid kit available. *Guidance: Refer to WorkSafeBC BC regulations section 3.16(2)(b) for basic first aid kit requirements.*	WorkSafeBC	
MSG1.1.5	**M**	There are procedures for managing violent and aggressive behavior.		

No.	Description	Reference	Change
MSG1.1.6	**M** There are procedures to protect staff "working alone" or in isolation. Guidance: "Working alone or in isolation" is defined as working in circumstances where assistance would not be readily available to the worker in case of emergency or if the worker is injured or becomes unwell.		
MGS1.2	**The medical office is prepared for disasters and emergencies.**		
MGS1.2.1	**M** Emergency exit routes are marked and provide an unimpeded exit.		
MGS1.2.2	**M** There are procedures for responding to medical emergencies.		
MGS1.2.3	**M** Staff are aware of the location of fire extinguishing equipment.		
MGS1.2.4	**M** Emergency instructions are posted in the office for easy reference.		
MGS1.3	**Adverse events and critical incidents are managed appropriately.**		
MGS1.3.1	**M** Adverse events and critical incidents are documented and reviewed.		
MGS1.3.2	**M** Policies and procedures for addressing adverse events and critical incidents are documented and available to staff.		
MGS1.3.3	**M** Changes are made to prevent recurrence of adverse events.		
MGS1.4	**Chemicals are used, stored and disposed of safely.**		
MGS1.4.1	**M** Chemicals are labeled appropriately. *Guidance: This applies to both the original supplier issued container and any secondary containers that have a workplace label indicating: product name; safe handling procedures; and reference to MSDS.*		
MGS1.4.2	**M** MSDS are available and current for controlled substances subject to WHMIS.	MSDS WHMIS	
MGS1.4.3	**M** Storage of chemicals complies with manufacturer's recommendations.		
MGS1.4.4	**M** Expiration dates of chemicals and cleaning agents are monitored.		
MGS1.4.5	**M** Chemicals are disposed of appropriately.		
MGS1.5	**Personal protective equipment (PPE) is available.**		
MGS1.5.1	**M** Adequate and appropriate PPE is available to protect staff from chemical or biological hazards.		
MGS1.5.2	**M** Latex-free gloves are available for staff and patients with latex sensitivities or allergies.		
MGS1.5.3	**M** PPE is put on, taken off and disposed of appropriately.		

No.	Description	Reference	Change
MGS1.6	**There is a procedure for managing blood and body fluid (BBF) exposure.**		
MGS1.6.1	**M** There is a BBF exposure procedure in place (e.g. needle stick injury). *Guidance: The BBF exposure procedure includes the reporting mechanism, who to contact and the required follow-up.*		
MGS1.7	**Safe and effective practices are followed for the use and disposal of sharps.**		
MGS1.7.1	**M** Used sharps are disposed of immediately in designated puncture resistant containers located in the immediate area where the sharps were used.		
MGS1.7.2	**M** Sharps containers are appropriately disposed. *Guidance: Sharps containers are sealed and replaced when they are at the fill line.*		
MGS1.8	**The design and layout of the physical environment ensures patient safety and privacy.**		
MGS1.8.1	**M** Patient areas are safe and clean.		
MGS1.8.2	Patient washrooms are clean, conveniently located and accessible.		
MGS1.8.3	**M** Furniture is safe for patient use.		
MGS1.8.4	**M** Patient information cannot be viewed by other patients or visitors.		
MGS1.8.5	**M** Patient privacy is not compromised during the diagnostic procedure.		

Patient safety

Patient safety is fundamental to the delivery of quality diagnostic services and optimal patient outcomes. A priority for all diagnostic services is to ensure that procedures are safe and that a continuous effort is made to improve patient safety.

No.		Description	Reference	Change
MPS1.0		**PATIENT SAFETY**		
MPS1.1		**The medical office creates a culture to ensure patient safety as a priority.**		
MPS1.1.1	**M**	Mechanisms are in place to address patient sensitivities and allergies. *Guidance: At a minimum, latex-free products are made available for both patients and staff (e.g. gloves, bandages).*		
MPS1.1.2	**M**	All patient safety incidents are documented in the patient's medical record. *Guidance: Patient safety incidents are documented and investigated using an adverse event and critical incident procedure.*		
MPS1.2		**Positive patient identification precedes commencement of the test or procedure.**		
MPS1.2.1	**M**	Patient identification is confirmed prior to testing by the person(s) performing the test.	WHO	
MPS1.2.2	**M**	At least two unique patient identifiers are used when verifying patient identification.	ISO 15189 5.4.3a CLSI QMS01-A4 6.1.1	
MPS1.2.3	**M**	Patients are involved in the identification process to the fullest extent possible.		
MPS1.2.4	**M**	Patient identity discrepancies are resolved prior to testing.		
MPS2.0		**MEDICATION MANAGEMENT AND ADMINISTRATION**		
MPS2.1		**The medical office has methods in place to ensure that medication is managed and administered to patients safely and effectively.**		
MPS2.1.1	**M**	Storage of medications complies with manufacturer's recommendations.		
MPS2.1.2	**M**	All stored medications are labeled with the contents, expiration date, and any warnings as applicable.		
MPS2.1.3	**M**	Medication containers are labeled with the medication name, strength and quantity when medications are prepared but not administered immediately.		

No.	Description	Reference	Change
MPS2.1.4	**M** The medical office regularly inspects all medication storage areas and medications.		
MPS2.1.5	**M** Only authorized staff obtain and administer medication.		
MPS2.1.6	**M** There are procedures on how to respond to adverse drug events (e.g. significant drug reactions, medication errors).		

Infection prevention and control

Infection prevention and control activities and precautions help reduce the possibility of acquiring and transmitting an infection. The type and scope of the activities and precautions are influenced by the size of the medical office, the resources available, the services provided, and the patients served.

No.	Description	Reference	Change
MIP1.0	**INFECTION PREVENTION AND CONTROL ACTIVITIES**		
MIP1.1	**Planning for infection prevention and control is effective, integrated and coordinated.**		
MIP1.1.1	**M** There are documented procedures for infection prevention and control. *Guidance: At a minimum, there are procedures for hand hygiene, personal protective equipment use, appropriate cleaning and disinfection of surfaces or items in the clinical environment).*		
MIP1.2	**Hand hygiene is used to prevent and control the spread of infection.** *Intent: Hand hygiene is the single most important activity for preventing the transmission of infections.*		
MIP1.2.1	**M** Hand hygiene is performed with plain soap and running water or alcohol based hand rubs.		
MIP1.2.2	**M** Hand hygiene is performed before and after direct contact with a patient.		
MIP1.2.3	**M** Hand hygiene is performed before putting on gloves for a clean or aseptic procedure and after gloves are removed.		
MIP1.3	**Gloves are worn by staff for protection against infection.** *Intent: Gloves are used as an additional measure, not as a substitute for appropriate hand hygiene. Gloves are not required for routine patient care activities.*		
MIP1.3.1	**M** Gloves are worn when there is potential for contact with blood or body fluids.		
MIP1.3.2	**M** Gloves are put on immediately before the activity for which they are indicated.		
MIP1.3.3	**M** Gloves are changed between patients and disposed of properly.		
MIPS1.4	**The physical environment of the diagnostic service is clean.**		
MIP1.4.1	**M** Equipment and surfaces in direct contact with a patient are cleaned and disinfected before use with another patient.		

No.		Description	Reference	Change
MIP1.4.2	**M**	A barrier (sheet or paper) is placed on the procedure table and changed between patients. Alternatively, the table is cleaned between patients.		
MIP1.4.3	**M**	Paper liners, linens, patient gowns, etc. are appropriately disposed of or laundered between patients.		
MIP1.5		**The medical office reduces the risk of infections associated with ancillary medical equipment.**		
MIP1.5.1	**M**	Routinely used patient testing equipment is cleaned or discarded between patients.		
MIP1.5.2	**M**	Single use medical devices are not reprocessed. *Intent: The reuse of single-use devices can affect their safety, performance, and effectiveness and expose patients and staff to unnecessary risk.*		
MIP1.6		**Hand washing sinks and eyewash stations are identified.**		
MIP1.6.1	**M**	There are sufficient, readily accessible hand hygiene sinks or other accessible forms of hand hygiene products.		
MIP1.6.2	**M**	There is a procedure for decontaminating sinks after cleaning equipment and prior to hand washing. *Guidance: If a hand washing sink is used for cleaning equipment, it is considered dirty and needs to be decontaminated prior to performing hand hygiene.*		
MIP1.6.3	**M**	Eyewash stations are available. *Guidance: Consult with WorkSafeBC to determine if an eyewash station is required based on the chemicals used in the diagnostic service. If required, refer to WorkSafeBC Occupational Health and Safety Regulation 5.85 and Tables 5-2 and 5-3.*		

Quality improvement

Every organization and diagnostic service, regardless of size, practices quality improvement to some degree. To improve the quality and safety of services provided to patients, the diagnostic service must continuously evaluate its performance. This information can be used to focus on improvement activities, and monitor the implementation of changes resulting from a structured continuous quality improvement process.

No.	Description	Reference	Change
MQI1.0	**QUALITY IMPROVEMENT** *The purpose of a quality improvement program (QIP) is to objectively and systematically monitor and evaluate the quality and appropriateness of services provided, and to pursue opportunities for improvement. For a QIP to be effective, it must be integrated into organization-wide improvement efforts and have assigned leadership and oversight. The size and structure of the organization and the diagnostic service will direct how comprehensive and resourced the QIP is.*		
MQI1.1	**There is an integrated and coordinated Quality Improvement Program.**		
MQI1.1.1	Quality improvement initiatives are developed, documented and implemented.		
MQI1.1.2	Indicators are defined to monitor the quality and safety of the diagnostic service.		
MQI1.1.3	Indicators give direction to quality improvement initiatives.		
MQI2.0	**MEDICAL PEER REVIEW** *Guidance: Medical peer review contributes to improving processes and outcomes by providing performance feedback to individual physicians. It is a proactive tool for identifying, tracking and resolving inappropriate clinical performance, discrepancies and medical errors during all stages of the diagnostic process. Peer review can be an internal process undertaken by peers within the organization, or a process external to the organization utilizing outside peers. Peer review may be performed on a 'case by case' basis in relation to critical incidents, complaints or medical staff reappointment processes. It may also be performed on randomly selected cases as part of a systematic effort to monitor performance of practitioners as a proactive complement to routine performance data collection and review.* *Individual physicians that do not work in a health authority are required to participate in a medical peer review program. Neurodiagnostic physicians participating in a health authority medical peer review program are not required to develop and implement an additional medical peer review program within their medical office.*		
MQI2.1	**The medical office improves quality through a medical peer review program.**		
MQI2.1.1	**M** Medical leadership for the medical peer review program is assigned.	DAP V1.1	

No.		Description	Reference	Change
MQI2.1.2	**M**	The medical leader is responsible to ensure the medical peer review program is developed, implemented and monitored.	DAP V1.1	
MQI2.1.3	**M**	The focus of the peer review program is quality improvement.	DAP V1.1	
MQI2.1.4	**M**	Individual results of medical peer review are communicated to the medical practitioner.	DAP V1.1	
MQI2.1.5		Aggregated results of medical peer review are communicated to the program participants.	DAP V1.1	
MQI2.1.6	**M**	Changes in practice are implemented as necessary.	DAP V1.1	
		The medical peer review program includes the following minimum elements:	DAP V1.1	
MQI2.1.7	**M**	For each interpreting physician, a defined number of reports are randomly selected for medical peer review.	DAP V1.1	
MQI2.1.8	**M**	Completeness and accuracy of reporting is assessed.	DAP V1.1	
MQI2.1.9	**M**	The number of cases reviewed is recorded and reported.	DAP V1.1	
MQI2.1.10	**M**	Significant discrepancies between the primary report and review are recorded and reported.	DAP V1.1	

Information management

Depending on the diagnostic service, the information management processes may be basic or complex; paper-based and electronic; or fully electronic information systems. Regardless of the process used, management and clinical information must be accurately captured and accessible.

No.		Description	Reference	Change
MIM1.0		**MEDICAL RECORD** *Guidance: The patient's medical record functions not only as a historical record of a patient's diagnostic procedure, but also as a method of communication between physicians and staff. The patient's medical record contains all the clinical data and information related to the patient's diagnostic procedures. These records facilitate the continuity of care and aid in clinical decision-making.*		
MIM1.1		**The medical office maintains complete and accurate medical records.**		
MIM1.1.1	**M**	The medical office uniquely identifies the patient and tests performed. *Guidance: There is a system for uniquely identifying patients and records used from the time the patient presents through all stages of testing. The medical office ensures that correct patient identification is maintained on all records, including reports. Every patient has a unique medical office issued patient identifying number and each test is uniquely associated to that patient.*		
MIM1.1.2	**M**	The patient name, patient identifying number and medical office name are clearly identified on the master file/patient medical record.		
MIM1.1.3	**M**	Current and historical clinical data can be accessed.		
MIM1.1.4		There is sufficient storage for hardcopy records (including test data).		
MIM2.0		**DOCUMENTATION RETENTION AND CONTROL**		
MIM2.1		**The diagnostic service retains documents and records.**		
MIM2.1.1	**M**	Medical records are stored according to the British Columbia's *Limitation Act*. *Reference: Ministry of Justice of British Columbia, http://www2.gov.bc.ca/gov/content/justice/about-bcs-justice-system/legislation-policy/legislation-updates/limitation-act.*	ISO 15189 4.13 GOBC LA	
MIM2.2		**The diagnostic service defines and maintains document control procedures.**		

No.		Description	Reference	Change
MIM2.2.1		Documents are identified by a title.		
MIM2.2.2		Documents are uniquely identified by a current revision date or version.		
MIM2.2.3		The individual responsible for the authorization and release of the document is clearly indicated (e.g. medical leader).		
MIM2.3		**The diagnostic service ensures that the integrity of the data is readily available and is safeguarded against harm.**		
MIM2.3.1	**M**	For computerized systems, database back-up is performed daily and the backup is securely located in a separate physical location. *Intent: If testing occurs less frequently, a database back-up is performed every day testing is conducted.*		
MIM2.3.2	**M**	Data is protected from unauthorized access and safeguarded against harm (e.g. water, fire, etc.).		

MIM3.0 PATIENT CONFIDENTIALITY AND PRIVACY

Intent: The protection of privacy and confidentiality is essential to maintaining trusting relationships between healthcare providers and patients. Health information can be electronic or paper; and can also be verbal. Breech in confidential information can occur when an individual is able to bypass security measures and systems to gain access to health information.

The medical office has legal and ethical obligations to maintain the confidentiality and privacy of the patient's information, including their personal health information. For more information please refer to https://www.cpsbc.ca/files/pdf/PSG-Medical-Records.pdf.

MIM3.1		**The diagnostic service protects the confidentiality of data and information.**		
MIM3.1.1	**M**	Data access is restricted, controlled and monitored.		
MIM3.1.2	**M**	Computer-based systems are password protected. *Intent: Generic login accounts are not used.*		
MIM3.1.3	**M**	There is a policy for the use and disclosure of personal information. *Intent: The policy must include the release of information to patients, family, other service areas, other organizations, for research or education purposes or legal reasons.*		
MIM3.1.4	**M**	Patient identification is removed before any secondary use is permitted (e.g. records used for research or teaching purposes are anonymized).		
MIM3.1.5	**M**	Confidential data is destroyed appropriately.		

Equipment

Diagnostic testing relies on the safe and optimal performance of the equipment. It is the expectation that the equipment performance meets manufacturer's specifications and complies with regulations.

No.	Description	Reference	Change
MES1.0	**EQUIPMENT**		
MES1.1	**Equipment is safely operated, maintained and monitored in a manner that ensures performance specifications are met.**		
MES1.1.1	**M** An orientation and training program is provided for all equipment to ensure safe, consistent, and accurate operation.		
MES1.1.2	**M** Equipment operators have access to the manufacturer's operator manual for the specific equipment used in the medical office.		
MES1.1.3	**M** Equipment is regularly checked for secure cable connections and any physical damage.		
MES1.1.5	**M** Scheduled preventative maintenance and safety checks of the diagnostic equipment are conducted as per manufacturers' recommendations. If there is no defined interval by the manufacturers' recommendation, then preventative maintenance occurs at a minimum every two years. *Guidance: This may include, but is not limited to current leakage, integrity of the ground wire, verifying amplifier gain, measurement of insulation resistance, current stimulator output in all ranges, etc.*	AANEM Position Statement, *Risks in the Electrodiagnostic Medicine*	REVISED
MES1.1.6	**M** There is a list of service staff and their contact information.		
MES1.1.7	**M** Equipment problems that impact test quality or safety are reported and repaired.		
MES1.1.8	**M** Any equipment that is not functioning as per manufacturer guidelines or poses a safety risk is removed from service and clearly labelled.		
MES1.2	**Equipment testing is performed prior to clinical use.**		
MES1.2.1	**M** New equipment has safety testing performed prior to clinical use.		
MES1.2.2	**M** Equipment complies with electrical safety regulatory requirements (e.g. Canadian Standards Association [CSA]).		

No.	Description	Reference	Change
MES1.2.3	**M** Equipment testing is performed by a qualified individual(s). *Intent: The individual evaluating the equipment has knowledge and /or additional training for its use (e.g. biomedical engineer, manufacturers' technical service specialist).*		
MES1.2.4	**M** Records of preventative maintenance and safety checks are retained for the lifetime of the equipment.		
MES1.2.5	**M** Prior to clinical use there is a process in place to verify the integrity of the relocated or refurbished equipment. *Intent: During a relocation assessment process the facility must demonstrate that the integrity of the equipment has been verified for clinical use.*		NEW

Neurodiagnostic testing

No.	Description	Reference	Change
MEMG1.0	**CONSULT REFERRALS**		
MEMG1.1	**Consult referrals are processed prior to performing an examination.**		
MEMG1.1.1	**M** Consults that lack the necessary information or contain errors are reconciled prior to the test.		
MEMG1.1.2	**M** There is a process for patient prioritization.		
MEMG1.2	**Consult referrals include accurate and comprehensive information.**		
MEMG1.2.1	**M** The consult referral includes the patient's first and last name.		
MEMG1.2.2	**M** The consult referral includes a unique personal identifier number (e.g. Provincial Health Number).		
MEMG1.2.3	**M** The consult referral includes the date of birth.		
MEMG1.2.4	**M** The consult referral includes the gender.		
MEMG1.2.5	**M** The consult referral includes the name and contact information of authorized individual.		
MEMG1.2.6	**M** The consult referral includes the name(s) of any other individual who is to receive a copy of the report.		
MEMG1.2.7	**M** The consult referral includes indication for testing. *Intent: The clinical information provided is sufficient in determining the most appropriate required examination(s).*		
MEMG1.2.8	The consult referral includes an indication of urgency. *Intent: There is an effective system in place to ensure patient prioritization.*		REVISED
MEMG1.2.9	The consult referral includes the date the request is received.		
MEMG2.0	**PATIENT PREPARATION**		
MEMG2.1	**Information for the examination is collected and assessed.**		
MEMG2.1.1	**M** Patient history is obtained and documented in the patient's medical record.		

No.		Description	Reference	Change
MEMG2.1.2	**M**	The examination includes a physical neuromuscular assessment of the patient. *Guidance: Electrodiagnostic studies serves as an extension of the clinical exam; therefore a direct neurological examination should be performed prior the studies in order to identify clinical issues and develop a working diagnosis.*		
MEMG2.1.3	**M**	Any factors that may affect the test are assessed and documented. *Guidance: At a minimum, the following factors are assessed and documented: skin temperature, patient history, physical neuromuscular assessment, indication for testing, the presence of cardiac assisted devices (e.g. implanted pacemaker, external pacing wires, etc.).*		
MEMG2.1.4	**M**	Skin temperature is documented.		NEW

MEMG3.0 PROCEDURES

MEMG3.1		**Procedures contain all the information necessary to perform the examination.** *Intent: Procedures ensure that examinations are performed consistently and accurately by all personnel within the medical office. Examination procedures may not be required for single physician practices.*		
MEMG3.1.1	**M**	Examination procedures are readily available to technical staff performing the examination.		
MEMG3.1.2	**M**	Techniques for recording motor and sensory responses are performed in accordance with the normative data used (e.g. recording electrode placement, stimulation sites, distances, waveform parameter measurements and conduction velocity calculations).		
MEMG3.1.3	**M**	Amplifier settings for motor and sensory recordings are consistent with the normative data used (e.g. LFF/HFF, gain, sweep speeds).		
MEMG3.1.4	**M**	Manufacturer's documentation is only used as a supplement to the examination procedure. *Intent: There should be documentation for all diagnostic procedures performed at the facility. Equipment or product information supplied by the manufacturer may be used to supplement procedural documentation but cannot be used as a substitute.*		
MEMG3.1.5	**M**	Manufacturer's changes to procedures are incorporated immediately.		
MEMG3.1.6	**M**	Procedures are reviewed every 1-3 years by qualified individual(s).		

No.		Description	Reference	Change
MEMG4.0		**EXAMINATION**		
MEMG4.1		**Nerve Conduction Studies (NCS) recording is conducted in a manner that ensures patient safety and the collection of accurate data.**		
MEMG4.1.1	**M**	EMG technologists perform nerve conduction studies with a physician readily available for consultation.		
MEMG4.1.2	**M**	Diagnostic testing is consistent with the examination procedures available to staff.		
MEMG4.1.3	**M**	Appropriate skin preparation is performed prior to the placement of electrodes.		
MEMG4.1.4	**M**	When attempts at eliminating artifact (physiological or non-physiological) have failed, it is documented.		
MEMG4.2		**Electromyography (EMG) recording is conducted in a manner that ensures patient safety and the collection of accurate data.**		
MEMG4.2.1	**M**	Only physicians perform EMG needle procedures.		
MEMG4.2.2	**M**	Gloves are worn when performing EMG needle procedures.		
MEMG4.2.3	**M**	Single-use needles are used for all non-single-fiber EMGs and disposed of properly.		
MEMG4.2.4	**M**	Appropriate skin preparation is performed prior to the insertion of EMG needles.		
MEMG4.2.5	**M**	Results for each muscle studied are documented, including the limb tested.		
MEMG5.0		**NORMATIVE DATA**		
MEMG5.1		**Normative data values are established and routinely employed.**		
MEMG5.1.1	**M**	A list of normative data values used is readily available.		
MEMG5.1.2	**M**	Normative values are quantifiable and reproducible.		
MEMG5.1.3	**M**	Normative values are available with consistent filter settings, sweep speeds, sensitivities, distances and electrode separations.		
MEMG5.1.4	**M**	The criteria used to establish non-published normative data are defined. *Guidance: At a minimum the following factors are assessed: published date, sample size, testing methods (e.g. filter settings, temperature control, filter settings, distances and electrode placement).*		

No.		Description	Reference	Change
MEMG6.0		**RECORDINGS**		
MEMG6.1		**Recordings are labeled in a standardized way that allows for proper patient identification.**		
MEMG6.1.1	**M**	Recordings are labeled with the patient's first and last name.		
MEMG6.1.2	**M**	Recordings are labeled with a second patient identifier (e.g. date of birth, personal health number).		
MEMG6.1.3	**M**	Recordings are labeled with the patient's gender.		
MEMG6.1.4	**M**	Recordings are labeled with the date of the test.		
MEMG6.1.6	**M**	Recordings are labeled with the identification of the recorder (e.g. name or initials).		
MEMG6.1.7		Recordings are labeled with the medical office name.		
MEMG7.0		**REPORTS** *Guidance: The report may include a combination of technical data, a consult letter or any other documents that would be necessary to help make a clinical decision.*		
MEMG7.1		**Diagnostic reports are in a standardized format that provides comprehensive and necessary information for clinical decision-making.**		
MEMG7.1.1	**M**	The final report includes the patient's first and last name.		
MEMG7.1.2	**M**	The final report includes a unique personal identifier number (e.g. Personal Health Number).		
MEMG7.1.3	**M**	The final report includes the date of birth.		
MEMG7.1.4	**M**	The final report includes the gender.		
MEMG7.1.5	**M**	The final report includes the medical office name.		REVISED
MEMG7.1.6	**M**	The final report includes the test(s) performed.		
MEMG7.1.7	**M**	The final report includes the individual performing test.		
MEMG7.1.8	**M**	The final report includes the name of authorized individual requesting the test.		
MEMG7.1.9	**M**	The final report includes other report recipient(s). *Guidance: Report recipient(s) may also be found on the clinical note; which should be attached to the report.*		

No.		Description	Reference	Change
MEMG7.1.10	**M**	The final report includes date of the test.		
MEMG7.1.11	**M**	The final report includes date of interpretation.		
MEMG7.1.12	**M**	Multiple page reports include patient identifiers on each sequentially numbered page.		
MEMG7.2		**Reports contain sufficient information to assist in diagnosis.**		
MEMG7.2.1	**M**	The body of the final report includes the procedure(s) performed.		
MEMG7.2.2	**M**	The body of the final report includes findings.		
MEMG7.2.3	**M**	The body of the final report includes potential limitations. *Guidance: The report, when appropriate, identifies factors that impact the* test *results.*		
MEMG7.2.4	**M**	The body of the final report includes an impression statement (e.g. conclusion or diagnosis). *Guidance: Unless the report is brief, each report contains an "impression" section.*		
MEMG7.2.5	**M**	The body of the final report includes comparison with previous test results and reports are included in final report, if available.		
MEMG7.2.6		The body of the final report includes recommendation(s) for follow-up.		
MEMG7.3		**A timely and accurate final report is issued for all tests.**		
MEMG7.3.1	**M**	Final reports are issued for all tests.		
MEMG7.3.2	**M**	Reports are signed by the reporting physician. *Guidance: Reports are verified and signed by a reporting physician either electronically or physically. If the content of the report is not verified by the author, there is a process in place to verify the accuracy of the transcription.*		
MEMG7.3.3	**M**	A copy of the final report is archived by the medical office as part of the patient's medical record and is retrievable for future reference.		
MEMG7.3.4	**M**	Medical staff responsible for the patient are notified of report delays in cases that may compromise patient care.		
MEMG7.4		**Corrected and addendum reports are appropriately identified and documented.**		
MEMG7.4.1	**M**	Corrected and addendum reports are clearly identified.		
MEMG7.4.2	**M**	Both the original and the new results are reported.		
MEMG7.4.3	**M**	The date and time the change was made is recorded.		

No.		Description	Reference	Change
MEMG7.4.4	**M**	Notification of clinical staff is recorded when there is a significant discrepancy between the original and the corrected or addendum report.		

MEMG8.0 URGENT/NON-ROUTINE TEST FINDINGS

MEMG8.1		**Urgent/non-routine test findings are effectively communicated.** *Guidance: There may be limited application for reporting urgent results; however, mechanisms for reporting urgent or non-routine results are necessary.*		
MEMG8.1.1	**M**	There is a procedure on communication of urgent and other non-routine test findings (e.g. critical findings/results). *Intent: A diagnostic service's procedure on communication can be an effective tool to promote patient care. The procedure can provide guidance on the types of communications that are most critical, the individuals responsible for receiving communications and the methods of communication that are most appropriate.* *Situations that may require urgent or non-routine communication include:* • *Findings that are discrepant with a preceding interpretation of the same test and where failure to act may adversely affect patient health. These cases may occur when the final interpretation is discrepant with a preliminary report or when significant discrepancies are encountered upon subsequent review of a study after a final report has been submitted.* • *Findings that the interpreting physician reasonably believes may be seriously adverse to the patient's health and are unexpected by the treating or referring physician. These cases may not require immediate attention but, if not acted upon, may worsen over time and possibly result in an adverse patient outcome.*		
MEMG8.1.2	**M**	Appropriate medical staff are notified by direct means (e.g. in person or by telephone) according to the medical office procedure for communication of urgent and other non-routine findings (e.g. critical results).		
MEMG8.1.3	**M**	Contingency plans are available in the event that the medical staff cannot be contacted.		
MEMG8.1.4	**M**	Notification and actions taken in response to urgent, unexpected or unusual findings are documented. *Guidance: The name of person to whom communication was made, the urgent findings, the date and time and method of communication is documented.*		

Glossary

This glossary has been adapted from one provided by the International Society for Quality in Health Care (ISQua). Some of ISQua's definitions have been altered to better reflect the needs of diagnostic facilities in British Columbia.

accreditation	A recognition of the achievement of accreditation standards by a diagnostic facility or organization, demonstrated through an independent external peer assessment of that organization's level of performance in relation to the Diagnostic Accreditation Program's standards criterion descriptors.
accreditation body	The organization responsible for the accreditation program and the granting of accreditation status.
accountability	Responsibility and requirement to answer for tasks or activities. This responsibility may not be delegated and must be transparent.
authorized individual	A term used to describe a physician or other designated health professional defined under relevant legislation as having the ability to request diagnostic tests.
AAET	American Association of Electrodiagnostic Technologists
ABEM	American Board of Electrodiagnostic Medicine
AANEM	American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM). Position Statement: *Risks in Electrodiagnostic Medicine*.
BCMQI	BC Medical Quality Initiative
best practice	An approach that has been shown to produce superior results, selected by a systematic process, and judged as exemplary, or demonstrated as successful. It is then adapted to fit a particular organization.
BRETC	Board of Registration of EMG Technologists of Canada.
CLSI QMS01-A4	Clinical and Laboratory Standards Institute, Quality

CPSBC	College of Physicians and Surgeons of BC
category	An achievable level of performance against which actual performance is compared. In DAP documents, categories are identified as whole numbers (i.e. 1.0, 2.0, 3.0…)
confidentiality	Guaranteed limits on the use and distribution of information collected from individuals or organizations.
consent	Voluntary agreement or approval given by a client.
credentialing	The process of assessing and attesting to an individual's knowledge, skills, and competence and their compliance with specific requirements.
criterion	Specific actions for each standard, criterion are identified by three digits (e.g. 1.1.1). A criterion is either a mandatory requirement for accreditation, or a best practice. Mandatory requirements are indicated by a bold type face **M**.
DAP V1.1	College of Physicians and Surgeons of British Columbia – Diagnostic Accreditation Program Community Neurodiagnostics Accreditation Standards
GOBC LA	Government of British Columbia, Limitation Act, Victoria, BC: Queen's Printer; 2012
human resources	The personnel requirements of the organization.
ISO 15189	International Standards Organization, ISO 15189 Medical laboratories – Requirements for quality and competence, Geneva, Switzerland: ISO; 2012
incidents	Events that are unusual, unexpected, may have an element of risk, or that may have a negative effect on patients, clients, staff, or the medical office.
information	Data that is organized, interpreted and used. Information may be in written, audio, video or photograph form.
information systems	Systems for planning, organizing, analyzing and controlling data and information, including both computer-based and manual systems.

leadership	Ability to provide direction and cope with change. It involves establishing a vision, developing strategies for producing the changes needed to implement the vision, aligning people, and motivating and inspiring people to overcome obstacles.
licensure	Process by which a government authority grants permission to an individual practitioner or health-care organization to operate or to engage in an occupation or profession.
management	The group or individual responsible for, or the activity of, setting targets or goals for the future through planning and budgeting, establishing processes for achieving those targets and allocating resources to accomplish those plans. Ensuring daily operation of the diagnostic setting. Ensuring that plans are achieved by organizing, staffing, controlling and problem-solving.
mandatory	A compulsory descriptor identified in the DAP standards. Mandatory requirements are indicated by a bold type face **M**. Unfulfilled mandatory criterion will result in immediate recommendations with specified time frames for follow-up.
medical leader	Is a physician with leadership responsibilities for a medical office.
medical office	A location outside of a health authority in which patients receive medical care.
MSDS	Material safety data sheet
orientation	The process by which staff become familiar with all aspects of the work environment and their responsibilities.
peer review	A process whereby the performance of an organization, individuals or groups are evaluated by members of similar organizations or the same profession or discipline and status as those delivering the services.
performance appraisal	The continuous process by which a manager appraises and a staff member reviews the staff member's performance, sets performance goals, and evaluates progress towards these goals.
procedures	Written specified instructions conveying the approved and recommended steps for a particular act or series of acts.

qualified	Having the credentials for, being professionally and legally prepared and authorized to perform specific acts.
quality improvement	A process that seeks to meet client's needs and expectations by using a structured approach to selectively identify areas to improve, and that improves all aspect of the services, including outcomes of service to patients and clients.
rights	Something that can be claimed as justly, fairly, legally or morally one's own. A formal description of the services that clients can expect and demand from an organization.
safety	The degree to which the potential risk and unintended results are avoided or minimized.
scope	The range and type of services offered by the organization and any conditions or limits to service coverage.
services	Products of the organization delivered to clients, or units of the organization that deliver products to clients.
staff	Individuals who contribute to the delivery of the diagnostic service. This includes both employees of the organization as well as independent contractors.
standard	A statement that contains one or more related specific criteria. A standard is identified by a two-digit number indicating the standards category that is associated to, and a second level identifier (e.g. 1.1).
WHMIS	Workplace Hazardous Materials Information System
WHO	World Health Organization. Patient Identification. May 2007, Volume 1, Solution 2. Geneva, Switzerland.
WorkSafeBC	WorkSafe BC Laboratory Health and Safety Handbook, 2008

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