COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

Diagnostic Accreditation Program

ACCREDITATION STANDARDS

Home Sleep Apnea Testing

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 College), the DAP has its mandate and authority 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 genetics
- 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 and criterion descriptors 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, criteria and criterion descriptors are directive in nature yet allow the diagnostic service flexibility in how they approach and address each element. The accreditation standards are high-level directive goal/outcome/deliverable statements that are to be reached. The accompanying criteria and criterion descriptors specify the activities that must be completed to support the standard being achieved.

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.

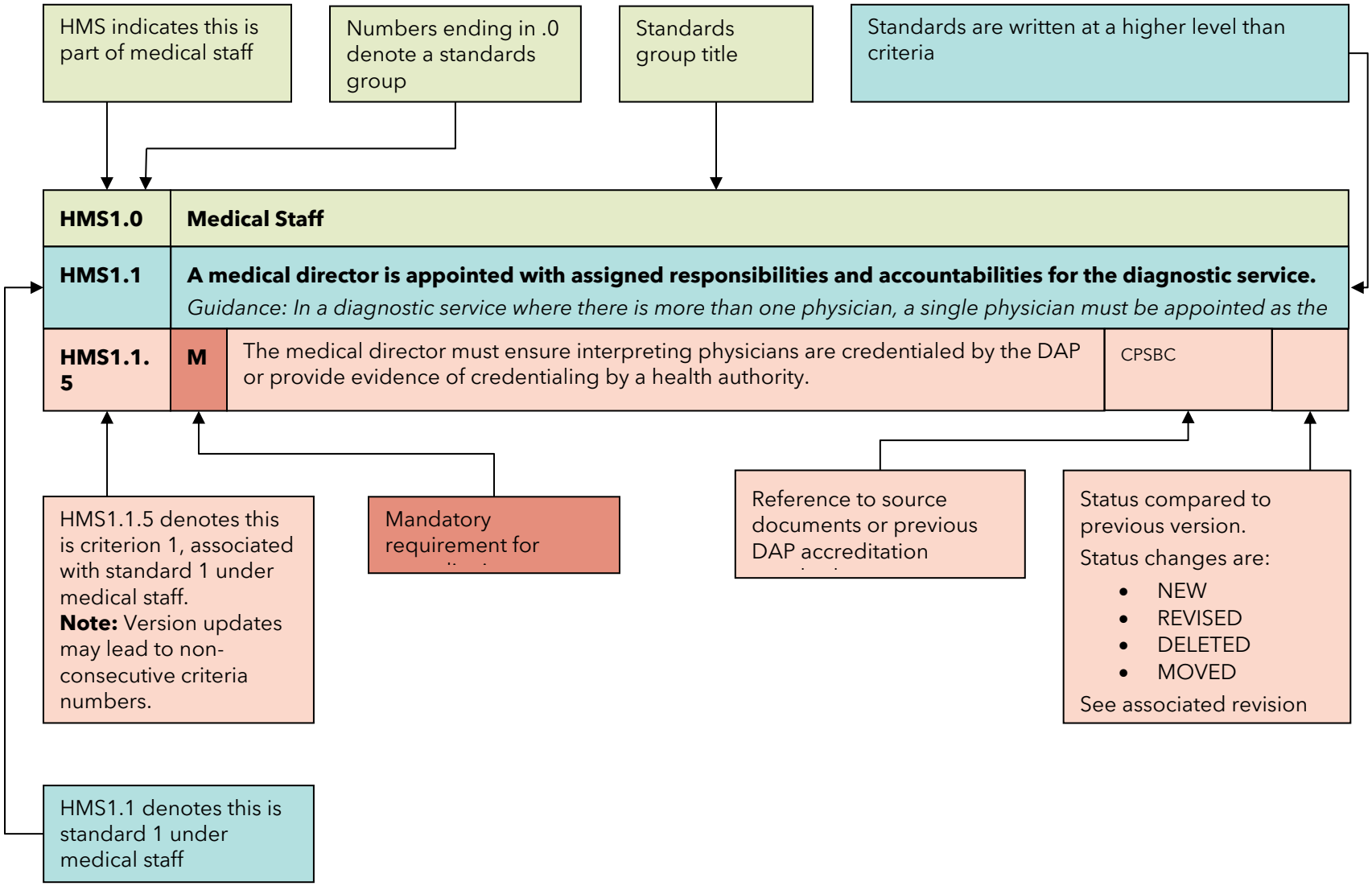
The DAP accreditation standards consist of three components:

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**.

Category codes

Governance and leadership	HGL
Medical staff	HMS
Human resources	HHR
Patient and client focus	HPC
General safety	HSA
Patient safety	HPS
Infection prevention and control	HIPC
Quality improvement	HQI
Information management	HIM
Equipment and supplies	HES
Global HSAT	HG
Home sleep apnea testing	HSAT

Example from the accreditation standards



Governance and leadership

Each organization has a governance and 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 facility.

No.		Description	Reference	Change
HGL1.0		**GOVERNANCE**		
HGL1.1		**The governing body/ownership is accountable for the quality and safety of care delivered by the diagnostic service.**		
HGL1.1.1	**M**	The governing body/ownership ensures effective internal structures and resources are in place to support quality and safety within the diagnostic service.		
HGL1.1.2	**M**	The governing body/ownership is committed to good professional practice examinations that are fit for intended use, compliant with the requirements of accreditation, consistent with national and international standards and encourage continual improvement of the quality of the services.	ISO 15189 4.1.2.3b	
HGL1.1.3		The governing body/ownership provides leaders with the training necessary to oversee the quality and safety of the service.		
HGL1.1.4	**M**	There is a documented and dated organizational chart with clear lines of accountability, responsibility, interrelationships, and authority. *Guidance: The organizational chart delineates the management structure of the service and identifies relationships within the organization (e.g. remotely located facility) and with other organizations.*	ISO 15189 4.2.2.2c ISO 15189 4.1.2.1d	
HGL1.1.5	**M**	The organization clearly outlines that the services provided by the facility are for the diagnosis and treatment of obstructed sleep apnea.		
HGL2.0		**LEADERSHIP**		
HGL2.1		**The accountability and responsibility for key leadership functions are assigned.**		
HGL2.1.1	**M**	A medical director (a licensed physician with the College) is appointed with responsibility for the quality and safety of the diagnostic service. *Guidance: The facility notifies the DAP when there is a change in medical directorship.*	CPSBC Bylaws s.5-30 (1)	

No.		Description	Reference	Change
HGL2.1.2	**M**	Individuals are appointed with responsibility for the quality and safety of operational processes and technical operations within the diagnostic service.		
HGL2.1.3	**M**	Appointed leaders work collaboratively to provide effective oversight of diagnostic service quality and safety.		

HGL3.0 ETHICS

HGL3.1		The diagnostic service promotes an environment that fosters and requires ethical and legal behaviour.		
HGL3.1.1	**M**	There is a written code of ethics for professional behaviour.		
HGL3.1.2	**M**	There is a process for addressing unethical or illegal behaviour.		
HGL3.1.3	**M**	The medical director must ensure that the facility follows the College practice standard for conflict of interest. https://www.cpsbc.ca/files/pdf/PSG-Conflict-of-Interest.pdf	CPSBC	
HGL3.1.4	**M**	The facility informs clients that the prescription for positive airway pressure (PAP) equipment is not restricted to their facility. Intent: The facility must communicate to clients that the prescription for PAP can be filled at any equipment provider.		
HGL3.1.5	**M**	There is a documented mechanism in place to ensure the patient is informed of their right to evaluate equipment treatment options at any location of their choice. *Guidance: The facility must post signage that is clearly visible or provide written communication to the patient. DAP recommended statement: [Name of facility] would like to communicate to our clients that you are not obliged to use our services and are free to use any company of your choice for the diagnosis and treatment of your obstructive sleep apnea.*		

Medical staff

The medical staff of the organization is comprised of those medical practitioners who hold a valid licence to practise medicine in British Columbia, and who have been appointed to the medical staff by the medical director of the organization. The medical director has a responsibility to ensure that only qualified and competent medical practitioners are appointed to the medical staff. The medical staff is accountable to the medical director.

Medical staff leadership

The medical director may have the title of medical director, or an alternate title. The medical staff are accountable to the medical director through the established medical staff structure.

In private diagnostic service facilities, the medical director is responsible for ensuring the competence of all physicians providing medical services within the organization.

If the medical director is the sole medical staff, they are responsible for ensuring that they are qualified and competent themselves to undertake the scope of medical service provided within the organization.

No.	Introduction		Reference	Change
HMS1.0	**MEDICAL STAFF**			
HMS1.1	**A medical director is appointed with assigned responsibilities and accountabilities for the diagnostic service.** *Guidance: In a diagnostic service where there is more than one physician, a single physician must be appointed as the medical director.*			
HMS1.1.1	**M**	The duties and responsibilities of the medical director are documented.		
HMS1.1.2	**M**	The diagnostic facility appoints a medical director with responsibility for all matters pertaining to the diagnostic service who is a registrant of the College of Physicians and Surgeons of British Columbia and whose credentials are acceptable to the DAP Committee. *Guidance: Although the medical director may be responsible for more than one facility, they must ensure that they can fulfill their responsibilities at all sites where they are appointed.*	College Bylaws s.5-30 (1)	
HMS1.1.3	**M**	The medical director ensures that all physicians and the facility are in compliance with the Bylaws of the College of Physicians and Surgeons of British Columbia.	College Bylaws s.5-30 (2)(d)-(e)	
HMS1.1.4	**M**	The medical director promptly notifies the DAP Committee of any change in the ownership or directorship of the facility or any significant change in service or operation.	College Bylaws s.5-30 (2)(d)	

No.		Introduction	Reference	Change
HMS1.1.5	**M**	The medical director must ensure interpreting physicians are credentialed by the College or provide evidence of credentialing by a health authority. https://www.cpsbc.ca/programs/dap/credentialing	CPSBC	
HMS1.1.6	**M**	The medical director works in collaboration with the ownership to grant physician privileges within the diagnostic service.	ISO 15189 4.1.1.2	
HMS1.1.7	**M**	The medical director establishes standardized interpretive comments and report formats.		
HMS1.1.8	**M**	The medical director authorizes the implementation of technical and medical operational policies and procedures related to the diagnostic service.		
HMS1.1.9	**M**	The medical director actively participates in quality oversight and improvement activities.		
HMS1.1.10	**M**	The medical director is responsible to ensure that the facility is in compliance with the DAP's quality control program for HSAT. *Guidance: In accordance with the DAP HSAT quality control program each facility must submit quality control data to the College for review.*		
HMS1.1.11	**M**	The medical director notifies the College when there is a change in a physicians' privileges. *Guidance: The medical director must take necessary action where competency issues are identified.*		
HMS1.2		**Interpreting physicians have the necessary credentials and experience to provide services.**		
HMS1.2.1	**M**	Credentials and experience of interpreting physicians are reviewed and approved by the medical director prior to granting privileges to interpret HSAT.		
HMS1.2.2	**M**	Physicians not affiliated with a health authority must be credentialed through the College. https://www.cpsbc.ca/programs/dap/credentialing	CPSBC	
HMS1.2.3	**M**	Interpreting physicians demonstrate ongoing continued professional development (CPD) in sleep medicine.		

Medical supervision of facilities

Facilities providing services without regular on-site medical directorship are remotely supervised. The medical director must maintain ongoing regular communication with the facility.

No.	Description	Reference	Change
HMS1.3	**The medical director attends the facility to assess the quality and safety of the service.**		
HMS1.3.1	**M** The medical director attends the facility to assess and to evaluate it prior to assuming responsibility for the medical directorship of the diagnostic service. *Guidance: The medical director assesses the complexity of the services provided and undertakes more frequent visits, if warranted. The visit may be done through virtual means but must include a video review of the facility.*		
HMS1.3.2	**M** At a minimum, the medical director assesses the diagnostic service annually. *Guidance: It is recommended that the medical director physically visit the facility annually; however, the medical director may assess the facility through virtual means. The virtual assessment must include a video review of the facility.*		
HMS1.4	**Logs to record the medical director's assessment of the supervised facilities are maintained.**		
HMS1.4.1	**M** A log is kept to record the medical director's assessment of the diagnostic service.		
HMS1.4.2	**M** Recommendations for improvement or required follow-up are recorded in the log.		
HMS1.5	**Roles of authority, responsibility and accountability are clearly defined and maintained at supervised facilities.**		
HMS1.5.1	**M** The medical director or designated interpreting physician maintains ongoing communication with the technical staff and referring practitioners.		
HMS1.5.2	**M** The facility ensures that there is a process in place for interpreting physicians to promptly reply to inquiries about interpreted studies.		

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.

For community-based facilities, the medical director and ownership are responsible to ensure that the physicians who practise in their facilities are appropriately privileged by reviewing the credentials of the physician and ensuring that the physician meets the credentialing and privileging dictionary requirements.

No.		Description	Reference	Change
HMS2.0		**THE DIAGNOSTIC SERVICE HAS QUALIFIED AND COMPETENT MEDICAL PRACTITIONERS**		
HMS2.1		**Information for each medical practitioner is collected, verified and assessed relative to the requested scope of practice/procedure.**		
HMS2.1.1	**M**	Information for each medical practitioner includes current licensure from the College of Physicians and Surgeons of British Columbia in the relevant specialty.	CPSBC	
HMS2.1.2	**M**	Information for each medical practitioner includes relevant education and training	CPSBC	
HMS2.1.3	**M**	Information for each medical practitioner includes the experience and competency to perform the scope of practice/procedure	CPSBC	
HMS2.2		**Medical staff only practice within the scope of their privileges.**		
HMS2.2.1	**M**	An accurate list of all medical practitioners practicing within the diagnostic service is maintained.		
HMS2.2.2	**M**	A record is maintained for each medical practitioner indicating the scope of service/procedures that they are permitted to practice within the diagnostic service, and this is communicated to the practitioner and the organization.		
HMS2.3		**Home sleep apnea testing is assessed and interpreted by qualified and competent physicians.**		

No.		Description	Reference	Change
HMS2.3.1	**M**	Physicians providing services for adult diagnostic HSAT have the requisite credentials for privileges as outlined in the Provincial Privileging Dictionaries. *Guidance: Polysomnography services are considered non-core privileges, depending on the relevant specialty; therefore, physicians may require further training, experience and demonstrated skills. Refer to http://bcmqi.ca/privileging-dictionaries/ for the requirements to perform diagnostic polysomnography.* *For additional information about physician credentials refer to the College's position statement on credentialing requirements for HSAT: https://www.cpsbc.ca/programs/dap/accreditation*	BCMQI CPSBC	

Medical staff contracts/agreements

Medical practitioners may be employees of an organization or may operate as independent medical practitioners under contract/agreement to a group or to the organization. Having a contract/agreement in place assists both parties to articulate expectations and communicates how disagreements will be resolved.

No.		Description	Reference	Change
HMS3.0		**MEDICAL STAFF CONTRACTS/AGREEMENTS**		
HMS3.1		**The diagnostic service effectively manages relationships with medical practitioners under contract/agreement.**		
HMS3.1.1	**M**	There is a documented contract/agreement in place between the medical director and the diagnostic service.		
HMS3.1.2	**M**	There is a documented contract/agreement in place between the interpreting physician(s) and the diagnostic service.		

Human resources

The diagnostic service 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 diagnostic service will be greatly affected by the quality of the staff working there.

The diagnostic service must have a strategy to ensure that qualified and competent staff are recruited and retained and that they are motivated and engaged in the work that they perform. This will help ensure that the needs and requirements of the diagnostic service and the population served are effectively met.

No.		Description	Reference	Change
HHR1.0		**HUMAN RESOURCES PLANNING**		
HHR1.1		**Human resource planning supports the diagnostic service's goals and objectives.**		
HHR1.1.1	**M**	There is a human resource plan to identify adequate staffing numbers and required competencies to meet the current and future needs of the diagnostic service.	ISO 15189 4.1.1.4 c ISQua 3.5	
HHR1.1.2	**M**	Human resource records are kept for all staff and are maintained in a confidential manner.		
HHR1.1.3	**M**	Job descriptions that reflect current practice, certification or registration and position responsibilities are available for all staff.		
HHR1.1.4	**M**	Staff undergoing training are always supervised by experienced and qualified personnel. *Intent: Patient safety and service standards are not compromised during, or as a result of, training.*	ISO 15189 5.1.5	
HHR1.1.5	**M**	Criminal record checks are performed for staff members who work with or may have unsupervised access to vulnerable adults. *http://www.bclaws.ca/Recon/document/ID/freeside/00_96086_01*	Criminal Records Review Act	
HHR1.1.6	**M**	There is a process for staff to bring forward concerns/complaints and for the diagnostic service leadership to respond in a fair, objective and timely manner.		
HHR2.0		**STAFF SELECTION AND RETENTION**		
HHR2.1		**The diagnostic service has qualified and competent staff to deliver services.**		
HHR2.1.1	**M**	The diagnostic service selects and recruits technical staff based on qualifications and experience (e.g. certification, knowledge, skills and reference checks).		

No.		Description	Reference	Change
HHR2.2		**Diagnostic HSAT sleep services are provided by registered polysomnographic technologist (RPSGT) who are qualified and competent.**		
HHR2.2.1	**M**	RPSGT staff providing HSAT services are certified by the Board of Registered Polysomnographic Technologists (BRPT).		
HHR2.2.2	**M**	Technical staff providing HSAT services who are graduates of an accredited training school of polysomnography and are eligible to undergo examination from the Board of Registered Polysomnographic Technologists (BRPT) have a defined period to become registered.		
HHR2.2.3	**M**	RPSGT comply with BRPT criteria. *Guidance: RPSGTs must achieve 50 educational credits over a five-year period and hold a valid CPR/BLS certificate.*	BRPT	
HHR2.3		**Diagnostic sleep services are provided by non-RPSGT who are qualified and competent.**		
HHR2.3.1	**M**	Staff who are qualified but non-registered in sleep technology have credentials as a certified polysomnographic technologist (CPSGT), registered respiratory therapist (RRT), registered nurse (RN) or licensed practical nurse (LPN).	AASM	
HHR2.3.2	**M**	The role of the non-RPSGT is defined and documented.		
HHR2.3.3	**M**	Appropriate training for non-RPSGT individuals providing sleep services is approved by the medical director.		
HHR2.3.4	**M**	Staff work under the supervision of a RPSGT, if their role(s) include scoring. *Guidance: Direct supervision by an RPSGT is required for CPSGT staff during training/ probationary periods. Supervision can change to remote supervision after sufficient training and approval by the medical director.*		
HHR2.4		**Diagnostic sleep services are provided by administrative staff who are qualified and competent.**		
HHR2.4.1	**M**	The role of administrative staff is defined and documented.		
HHR2.4.2	**M**	For diagnostic sleep services, the role is limited to HSAT equipment set-up/download.		
HHR2.4.3	**M**	Appropriate training for administrative staff providing sleep services is approved by the medical director.		
HHR2.4.4	**M**	A qualified staff member is readily available for assistance. *Guidance: If the defined role includes responsibilities for diagnostic sleep services, then a qualified staff member should be available for assistance.*		

No.	Description	Reference	Change
HHR3.0	**HSAT ADMINISTRATION AND SCORING STAFF**		
HHR3.1	**Staff receive orientation and training for the administration of HSAT devices to ensure patient safety and collection of accurate data.**		
HHR3.1.1	**M** Staff receive training for the equipment operation, application of sensors, use, maintenance, warnings and safety.	AASM	
HHR3.1.2	**M** Staff receive training on patient instructions.	AASM	
HHR3.1.3	**M** Staff receive training on troubleshooting of the HSAT device.	AASM	
HHR3.1.4	**M** Staff receive training in infection prevention and control procedures (e.g. cleaning and disinfection).	AASM	
HHR3.1.5	**M** Staff receive training on procedures for a patient to contact them if they experience problems with the HSAT exam.		
HHR3.2	**HSAT scoring is conducted in a manner that ensures accurate data for interpretation and diagnosis.**		
HHR3.2.1	**M** Scoring of studies is conducted or supervised by registered polysomnographic technologist (RPSGT) staff.		
HHR3.2.2	**M** CPSGT staff providing scoring services have appropriate training approved by the medical director and work under the supervision of a RPSGT.		
HHR3.2.3	**M** Outsourced scoring services must be conducted by a RPSGT, located in Canada, have a QA program in place, and be approved by the medical director.	FOIPPA	
HHR3.2.4	**M** All staff providing scoring services participate in an interscorer reliability program.		
HHR4.0	**ORIENTATION AND TRAINING**		
HHR4.1	**Orientation and training for the safe provision of quality diagnostic services are provided.** *Intent: Staff training is an ongoing quality improvement initiative.*		
HHR4.1.1	**M** Staff receive orientation and training to address adverse events and critical incident reporting.		
HHR4.1.2	**M** Staff receive orientation and training to address patient identification.		
HHR4.1.3	**M** Staff receive orientation and training to address WHMIS (e.g. appropriate disposal of solutions and supplies).		

No.		Description	Reference	Change
HHR4.1.4	**M**	Staff receive orientation and training to address staff injury reporting.		
HHR4.1.5	**M**	Staff receive orientation and training to address fire safety procedures *Guidance: Staff are aware of the location of firefighting equipment and actions taken when a fire occurs.*		
HHR4.1.6	**M**	Staff receive orientation and training to address management of aggressive behaviour.		
HHR4.1.7	**M**	Staff receive orientation and training to address medical emergency procedures (e.g. cardiac arrest). *Guidance: The emergency management procedure may include accessing emergency management services.*		
HHR4.1.8	**M**	Staff receive orientation and training to address information management systems.		
HHR4.1.9	**M**	Staff receive orientation and training to address confidentiality of data and information.		
HHR4.1.10	**M**	Staff receive orientation and training to address infection prevention and control (e.g. hand washing, blood and body fluid exposure, proper use of PPE).		
HHR4.1.11	**M**	Staff receive orientation and training to cleaning and disinfection procedures for medical devices.		
HHR4.2		**The competency of technical staff is assessed.**		
HHR4.2.1	**M**	Competency assessments for technical staff are documented and performed to evaluate the knowledge, skills and abilities of the staff to ensure they are proficient in performing their duties.		
HHR4.2.2	**M**	Competency assessments for technical staff are conducted annually.		
HHR4.2.3	**M**	A documented action plan is developed when a staff member's competence does not meet the medical director's expectations.		
HHR4.2.4	**M**	The action plan is approved by the medical director.		
HHR4.3		**Individual staff members receive performance feedback.**		
HHR4.3.1	**M**	Performance appraisals are conducted annually and are based on job responsibilities and expectations.		
HHR4.4		**Staff are supported and provided with ongoing education, training and professional development.**		
HHR4.4.1		Professional development and continuing education are encouraged and supported.		
HHR4.4.2		Staff participate in ongoing education, training and professional development to meet the needs of the diagnostic service.		

No.	Description	Reference	Change
HHR4.5	**Participation in clinical teaching does not compromise patient care.**		
HHR4.5.1	**M** Patient care is not compromised during or as a result of clinical teaching.		

Patient and client focus

Engaging and involving patients in their health care ensures that their needs are met in a safe and effective manner. A patient- and client-focused culture enables the diagnostic service to be 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-centred services, including how the diagnostic service determines the requirements, expectations and preferences of patients and clients. Examples of clients may include patients, referring physicians, WorkSafeBC, and insurance companies.

No.		Description	Reference	Change
HPC1.0		**PATIENT AND CLIENT FOCUS**		
HPC1.1		**Service standards of the diagnostic service are defined and communicated to patients and clients.**		
HPC1.1.1		The time from referral to the test/consultation is monitored.		
HPC1.1.2		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.*		
HPC1.2		**Interpreting physicians are responsive to patient and physician inquiries.**		
HPC1.2.1	**M**	Interpreting physicians and designated facility staff are responsive to case-specific inquiries.		
HPC1.3		**Patients are involved in decision making about their care and procedure(s).**		
HPC1.3.1	**M**	Patients are provided with information about their procedure(s) and care to make informed decisions. *Guidance: Refer to HGL3.0 Ethics.*		
HPC2.0		**PATIENT AND CLIENT SATISFACTION**		
HPC2.1		There is a process in place to gather feedback and follow-up on patient complaints.		
HPC2.1.1	**M**	There are methods to identify complaints that require specific action.		
HPC2.1.2	**M**	There is a procedure for documenting complaints from patients and clients.		

No.	Description		Reference	Change
HPC2.1.3	**M**	Responses to patient and client inquiries and complaints are addressed promptly and effectively.		
HPC2.1.4	**M**	The resolution of complaints is documented.		
HPC2.1.5	**M**	There is a mechanism to capture patient or client feedback.		
HPC2.1.6	**M**	Information obtained from complaints or feedback is used to make improvements.		
HPC2.2	**There is a process in place to gather feedback from referring physicians.**			
HPC2.2.1	**M**	There is a documented procedure to obtain feedback from referring physician(s) on an annual basis.		
HPC2.2.2	**M**	There is a process to review feedback by the medical director.		
HPC2.2.3	**M**	Feedback obtained from referring physicians is used to make improvements.		

General safety

The general safety accreditation standards include those most common to a diagnostic service; 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
HSA1.0		**GENERAL SAFETY**		
HSA1.1		**Potential hazards and risks to staff, patients and visitors are minimized.**		
HSA1.1.1	**M**	Safety issues are discussed and monitored. *Guidance: For small organizations with less than 20 employees, the employer must initiate and maintain a 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	
HSA1.1.2	**M**	Regular inspections of the work area, equipment, and practices are performed at a defined interval as determined by the facility 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.*	WorkSafeBC	
HSA1.1.3	**M**	Safety concerns are addressed immediately.		
HSA1.1.4	**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	
HSA1.1.5	**M**	There are procedures for managing violent and aggressive behaviour.		
HSA1.1.6	**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.*		

No.		Description	Reference	Change
HSA1.2	**The diagnostic service is prepared for disasters and emergencies.**			
HSA1.2.1	**M**	Emergency exit routes are marked and provide an unimpeded exit.		
HSA1.2.2	**M**	There are procedures for responding to medical emergencies.		
HSA1.2.3	**M**	Staff are aware of the location of fire extinguishing equipment.		
HSA1.2.4	**M**	Emergency instructions are posted in the office for easy reference.		
HSA1.3	**Chemicals are used, stored and disposed of safely.**			
HSA1.3.1	**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 Material Safety Data Sheet (MSDS).*	WorkSafeBC	
HSA1.3.2	**M**	MSDS are available and current for controlled substances subject to Workplace Hazardous Materials Information System (WHMIS).	WorkSafeBC	
HSA1.3.3	**M**	Storage of chemicals complies with manufacturer's instructions.		
HSA1.3.4	**M**	Expiration dates of chemicals and cleaning agents are monitored.		
HSA1.3.5	**M**	Chemicals are disposed of appropriately.		
HSA1.4	**Personal protective equipment (PPE) is available.**			
HSA1.4.1	**M**	Adequate and appropriate PPE is available to protect staff from chemical or biological hazards.		
HSA1.4.2	**M**	Latex-free gloves are available for staff and patients with latex sensitivities or allergies.		
HSA1.4.3	**M**	PPE is put on, taken off and disposed of appropriately.		
HSA1.5	**The design and layout of the physical environment ensures patient safety and privacy.**			
HSA1.5.1	**M**	Patient areas are safe and clean.		
HSA1.5.2		Patient and staff washrooms are clean, conveniently located, and accessible.		
HSA1.5.3	**M**	Furniture within the facility is safe for patient use.		
HSA1.5.4	**M**	Patient information cannot be viewed by other patients or visitors.		
HSA1.5.5	**M**	Patient privacy is not compromised during the diagnostic process.		

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.		Reference	Reference	Change
HPS1.0	**PATIENT SAFETY**			
HPS1.1	**The diagnostic service creates a culture to ensure that patient safety is a priority.**			
HPS1.1.1	**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, tape, bandages).*		
HPS1.1.2	**M**	All patient safety incidents are documented in the patient's medical record. *Guidance: Patient safety incidents are documented and investigated.*		
HPS1.2	**Positive patient identification precedes commencement of the test or procedure.**			
HPS1.2.1	**M**	Patient identification is confirmed prior to testing by the person(s) performing the test.	WHO	
HPS1.2.2	**M**	At least two unique patient identifiers are used when verifying patient identification.		
HPS1.2.3	**M**	Patients are involved in the identification process to the fullest extent possible.		
HPS1.2.4	**M**	Patient identity discrepancies are resolved prior to testing.		

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 diagnostic service, the resources available, the services provided, and the patients served.

No.	Description	Reference	Change
HIPC1.0	**INFECTION PREVENTION AND CONTROL ACTIVITIES**		
HIPC1.1	**Planning for infection prevention and control is effective, integrated and coordinated.**		
HIPC1.1.1	**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 equipment and surfaces. Additional information is available at https://www.cpsbc.ca/programs/pomdra/additional-resources.*		
HIPC1.2	**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.*		
HIPC1.2.1	**M** Hand hygiene is performed with soap and running water or alcohol-based hand rubs (ABHR).		
HIPC1.2.2	**M** Hand hygiene is performed before and after direct contact with a patient.		
HIPC1.2.3	**M** Hand hygiene is performed before putting on gloves and after gloves are removed.		
HIPC1.3	**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.*		
HIPC1.3.1	**M** Gloves are worn when there is potential for contact with blood or body fluids.		
HIPC1.3.2	**M** Gloves are put on immediately before the activity for which they are indicated.		
HIPC1.3.3	**M** Gloves are removed and disposed of appropriately after the activity.		
HIPC1.4	**The physical environment of the diagnostic service is clean.**		
HIPC1.4.1	**M** Equipment and surfaces in direct contact with a patient are cleaned and disinfected before use with another patient.		
HIPC1.5	**Hand washing sinks and eyewash stations are identified.**		

No.		Description	Reference	Change
HIPC1.5.1	**M**	There are sufficient, readily accessible hand hygiene sinks or other accessible forms of hand hygiene products.		
HIPC1.5.2	**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.*		
HIPC1.5.3	**M**	Eyewash stations are available, if required. *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.*	WorkSafeBC	

HIPC2.0 MEDICAL DEVICE REPROCESSING

HIPC2.1		**The diagnostic service reduces the risk of infections associated with medical devices.**		
HIPC2.1.1	**M**	Dirty equipment is handled in a safe manner to reduce the risk of exposure and is placed in an appropriate receptacle after use.	CPSBC BC MoH	
HIPC2.1.2	**M**	Staff assigned to reprocessing medical devices have completed training in reprocessing.		
HIPC2.1.3	**M**	Clean equipment is stored in a manner to prevent contamination and is safeguarded from harm until the point of use.		
HIPC2.1.4	**M**	Staff have access to the manufacturer's instructions for use for all medical devices.		
HIPC2.1.5	**M**	Mask fitting sizing tools are single-patient use only (e.g. sizing guides).		
HIPC2.1.6	**M**	Masks are single-patient use only. *Guidance: Masks are considered single-patient use and must not be used on another patient including for mask sizing purposes.*		
HIPC2.2		**Single-use medical devices are used for diagnostic or treatment purposes, where available.**		
HIPC2.2.1	**M**	When available, single-use medical devices are used.		
HIPC2.2.2	**M**	When available, single-use non-critical medical devices are used. *Note: Non-critical devices refer to equipment/devices that only touch intact skin and not mucous membranes (e.g. pulse oximeter probes, end of line filters).*		

No.		Description	Reference	Change
HIPC2.2.3	**M**	When available, single use semi-critical medical devices are used. *Note: Semi-critical devices refer to equipment/devices that comes into contact with/exposure to mucous membranes or non-intact skin (e.g. nasal cannula, hose, mask).*		
HIPC2.2.4	**M**	Single-use medical devices are not reprocessed. *Intent: Single-use (disposable) medical devices are not intended to be reused, reprocessed, or used on another patient.*		
HIPC2.2.5	**M**	If a medical device's details are unavailable or are inappropriately labeled, it should be considered single use only.		
HIPC2.3		**When only multi-use reusable medical devices are available for diagnostic or treatment purposes standardized reprocessing practices are implemented.** *Guidance: The reprocessing method required for medical equipment/devices will depend on the intended use of the equipment, manufacturers' instructions and the potential risk of infection involved with its use.*		
HIPC2.3.1	**M**	For all reusable semi-critical medical devices (e.g. humidifier, hose, mask), the practice of high-level disinfection (HLD) using chemical solutions (soaking) is not permitted. *Guidance: Consider switching to single use disposable devices or treat reusable devices as single patient use only devices that are not used on another patient. Some examples of HLD chemicals solutions are those containing agents such as hydrogen peroxide, glutaraldehyde, orthophthalaldehyde, and peracetic acid.* *For additional information refer to https://www.cpsbc.ca/programs/pomdra/mdr-faqs.*	CPSBC BC MoH	
HIPC2.3.2	**M**	If reprocessing reusable semi-critical medical devices then only HLD by pasteurization or sterilization can be used, provided it is validated by the manufacturer.	CPSBC BC MoH	
HIPC2.3.3	**M**	Multi-use reusable non-critical devices (e.g. recording unit, effort belt, PAP machine, pulse oximeters) must be cleaned and low-level disinfected (LLD).		
HIPC2.3.4	**M**	Manufacturer's instructions for use must be followed when reprocessing any multi-use reusable device.	CPSBC BC MoH	

Quality improvement

The purpose of a quality improvement program (QIP) is to monitor and evaluate the quality and appropriateness of services provided objectively and systematically, 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.

No.	Description	Reference	Change
HQI1.0	**QUALITY IMPROVEMENT**		
HQI1.1	**The diagnostic service has a forum for discussing quality improvement initiatives.**		
HQI1.1.1	Quality improvement initiatives are regularly discussed with the facility staff.		
HQI1.1.2	Plans for improvement initiatives are defined and documented.		
HQI1.1.3	Quality improvement initiatives are evaluated after implementation.		

Quality control

Quality control is a process of monitoring the accuracy and reproducibility of a test procedure, but it also takes into account a number of aspects, any one of the which may impact patient results. These aspects include the pre-test, test and post-test aspects of the diagnostic test. This process can be an internal process undertaken by peers within the organization, or a process external to the organization using outside peers. Review may be performed on a case-by-case basis or may be 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.

No.		Description	Reference	Change
HQI2.0		**QUALITY CONTROL**		
HQI2.1		**HSAT facilities participate in a quality control program to evaluate and improve their scope of service.**		
HQI2.1.1	**M**	The medical director ensures the facility participates in the HSAT quality control program established by the DAP.		
HQI2.1.2	**M**	Roles and responsibilities for submitting quality control program details are assigned.		

No.	Description	Reference	Change
HQI2.1.3	**M** Findings from the quality control program are reviewed by the medical director and preventative action is taken to improve processes, as necessary.		
HQI2.1.4	**M** The medical director is responsible to ensure individual results of the quality control program are communicated to the appropriate individual.		
HQI2.1.5	**M** A record of corrective action is available for review.		
HQI2.1.6	The focus of the quality control program is for quality improvement purposes.		

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
HIM1.0	**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 among 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.*		
HIM1.1	**The diagnostic service maintains complete and accurate medical records.**		
HIM1.1.1	**M** The diagnostic service 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 diagnostic service ensures that correct patient identification is maintained on all records, including reports. Every patient has a unique facility-issued patient identifying number, and each test is uniquely associated to that patient.*		
HIM1.1.2	**M** The patient name, patient identifying number and facility name are clearly identified on the master file/patient medical record.		
HIM1.1.3	**M** Current and historical clinical data can be accessed.		
HIM2.0	**DOCUMENTATION RETENTION AND CONTROL**		
HIM2.1	**The diagnostic service retains documents and records.**		
HIM2.1.1	**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.*		

No.		Description	Reference	Change
HIM2.1.2	**M**	Medical records are made available to the patient or healthcare provider upon request in a timely manner. *Intent: Medical records, including test results, are available for review to assist in the treatment options or additional testing.*		
HIM2.2		**The diagnostic service defines and maintains document control procedures.**		
HIM2.2.1	**M**	Documents are identified by a title.		
HIM2.2.2	**M**	Documents are uniquely identified by a current revision date or version.		
HIM2.2.3	**M**	The individual responsible for the authorization and release of the document is clearly indicated (e.g. medical director).		
HIM2.2.4	**M**	Only current authorized versions of documents are available for active use and invalid or obsolete documents are promptly removed from all points of use.		
HIM2.3		**The diagnostic service ensures that the integrity of the data is maintained and is readily available.**		
HIM2.3.1	**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.*		
HIM2.3.2	**M**	Data are protected from unauthorized access and safeguarded against harm (e.g. water, fire, etc.).		
HIM2.3.3	**M**	Raw unscored data are stored and available for review.		

HIM3.0 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, paper, and verbal. A breech in confidential information can occur when an individual is able to bypass security measures and systems to gain access to health information. The diagnostic service 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.

HIM3.1		**The diagnostic service protects the confidentiality of data and information.**		
HIM3.1.1	**M**	Data access is restricted, controlled, and monitored.		

No.	Description	Reference	Change
HIM3.1.2	**M** Computer-based systems are password protected. *Intent: Generic login accounts are not used.*		
HIM3.1.3	**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.*		
HIM3.1.4	**M** Patient identification is removed before any secondary use is permitted (e.g. records used for research or teaching purposes are anonymized).		
HIM3.1.5	**M** Confidential data is destroyed appropriately.		

Equipment and supplies

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
HES1.0		**EQUIPMENT**		
HES1.1		**Equipment is safely operated, maintained, and monitored in a manner that ensures performance specifications are met.**		
HES1.1.1	**M**	Equipment capabilities contain the required parameters for its intended use. *Intent: At a minimum, equipment recording features include the ability to record oximetry, heart rate, airflow, respiratory effort or equivalent and allow for the editing of raw data.*		
HES1.1.2	**M**	An orientation and training program is provided for all equipment to ensure safe, consistent, and accurate operation.		
HES1.1.3	**M**	Equipment operators have access to the manufacturer's operator manual for the specific equipment used in the diagnostic service.		
HES1.1.4	**M**	Equipment is regularly checked for secure cable connections and any physical damage.		
HES1.1.5	**M**	Scheduled preventative maintenance and replacement of parts for the diagnostic equipment are conducted as per manufacturer's instructions.		
HES1.1.6	**M**	Manufacturer-issued defects, recalls and safety advisories are acted upon immediately.		
HES1.1.7	**M**	There is a list of service staff and their contact information.		
HES1.1.8	**M**	Equipment problems that impact test quality or safety are reported and repaired.		
HES1.1.9	**M**	Any equipment that is not functioning as per manufacturer guidelines or poses a safety risk is removed from service and clearly labelled.		
HES1.1.10	**M**	Diagnostic testing equipment is safeguarded from harm when not in use.		
HES1.2		**Equipment testing is performed prior to clinical use.**		
HES1.2.1	**M**	New equipment is evaluated by a qualified individual prior to clinical use.		
HES1.2.2	**M**	Equipment complies with electrical safety regulatory requirements (e.g. Canadian Standards Association (CSA)).		

No.	Description	Reference	Change
HES1.2.3	**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, technical specialist).*		
HES1.2.4	**M** Records of preventative maintenance and safety checks are retained for the lifetime of the equipment.		
HES1.2.5	**M** The DAP is notified of new or replaced equipment prior to clinical use. *Guidance: A Notice of Significant Change in Service form is submitted to the DAP along with any validation reports prior to clinical use of the equipment.*		
HES1.2.6	**M** There is a record that new or refurbished equipment has been authorized for use by a qualified individual. *Guidance: Prior to clearance for clinical use the equipment must have gone through a validation process and the results reviewed by a qualified individual.*		

HES2.0 SOLUTIONS AND SUPPLIES

HES2.1	**The storage and monitoring of solutions and supplies ensure an effective inventory control system.**		
HES2.1.1	**M** Storage complies with manufacturer's instructions.		
HES2.1.2	**M** Expiration dates are monitored.		
HES2.1.3	**M** Rejected/expired goods are clearly marked and dealt with appropriately.		
HES2.1.4	**M** Inventory control problems and actions taken are documented.		
HES2.1.5	**M** There is a process for resolving non-compliance or quality issues with the vendor in a timely manner.		

Global HSAT

The global modality accreditation standards examine those practices related to pre-examination, examination and post-examination processes in relation to the performance of the diagnostic test.

No.	Description	Reference	Change
HG1.0	**TEST REQUESTS**		
HG1.1	**Test requests are standardized and ensure that accurate, comprehensive, and appropriate information is relayed.** *Guidance: Requests are to be completed for all diagnostic tests.*		
HG1.1.1	**M** Tests are only performed when requested by authorized individuals. *Guidance: There is a facility policy that defines "authorized individual" as medical physicians, nurse practitioners, and other designated health professionals as permitted by governing legislation, rules, and bylaws.*		
HG1.1.2	**M** Requests that lack the necessary information or contain errors are reconciled prior to the test.		
HG1.1.3	**M** Authorized individuals requesting tests are notified when tests are cancelled by the diagnostic service.		
HG1.1.4	**M** Processes are in place to assess test appropriateness. *Intent: Test appropriateness is evaluated by the medical director or qualified designate prior to testing. The medical director is available to the designate, if required.*		
HG1.1.5	**M** Referrals identified as inappropriate are returned to the referring physician and include a comment as to the reason.		
HG1.1.6	**M** Rejected referrals are documented by the facility and regularly reviewed by the medical director.		
HG1.1.7	**M** A single repeat test is conducted, if warranted. *Guidance: Inconclusive or technically inadequate testing may require a level I polysomnography.*	AASM	
HG1.2	**Test requests contain accurate and appropriate information.**		
HG1.2.1	**M** Standardized referrals developed by the Guidelines and Protocol Advisory Committee (GPAC) are used.	Approved Standard Diagnostic Outpatient Requisition Forms (gov.bc.ca)	

No.		Description	Reference	Change
HG2.0		**PATIENT PREPARATION**		
HG2.1		**Patients are appropriately prepared and assessed for the test being performed.**		
HG2.1.1	**M**	Patient instructions are communicated to the patient prior to the test. *Guidance: Test details on what to expect are communicated to the patient prior to the administration of the test.*		
HG2.1.2		Patient instructions are available in a variety of languages considering the population served.		
HG2.1.3	**M**	Any factors that may affect the test are documented and considered.		
HG2.1.4	**M**	Processes ensure relevant prior tests are available for comparison.		
HG2.1.5	**M**	Patient histories are obtained, and relevant clinical history is recorded (e.g. patient questionnaire). *Guidance: A patient's medical condition may change if a reasonable wait time from point of referral to test is exceeded.*		
HG2.1.6	**M**	Patients are assessed for contraindications to the procedure or other exclusion criteria. *Guidance: When required, the technologist should consult with the physician, nursing staff and/or caregiver concerning the patient's condition and any limitations.*		
HG3.0		**PROCEDURES AND DOCUMENTATION**		
HG3.1		**Standardized procedures are used in diagnostic facilities to obtain test results.**		
HG3.1.1	**M**	All procedures are documented, communicated to, and available to staff performing the testing.		
HG3.1.2	**M**	Manufacturer's documentation is only used as a supplement to the diagnostic facilities 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.*		
HG3.1.3	**M**	Manufacturer's changes to procedures are incorporated in a timely manner.		
HG3.1.4	**M**	At a minimum, procedures are reviewed every three years by the medical director.		

No.	Description	Reference	Change
HG3.1.5	**M** Documentation contains all the relevant information necessary to perform the test. *Guidance: Relevant information necessary to perform the test may include title, purpose, process flowchart, testing instructions, supporting documents, equipment and maintenance or special safety precautions.*		
HG3.1.6	**M** Procedures are approved by the medical director prior to use.		
HG3.2	**Procedure manuals are current, accurate, and available to staff.**		
HG3.2.1	**M** Procedural manuals are comprehensive and reflect the scope of service(s) offered by the facility.		
HG3.2.2	**M** Procedural manuals include the name of test.		
HG3.2.3	**M** Procedural manuals include details for the equipment used. *Guidance: Procedural manuals include the model of recorder, type of pulse oximeter and type of effort belt or equivalent.*		
HG3.2.4	**M** Procedural manuals include test set-up details.		
HG3.2.5	**M** Procedural manuals include test downloading protocols.		
HG4.0	**RECORDINGS AND MEDICAL RECORDS**		
HG4.1	**Recordings and medical records are labeled in a standardized way that allows for proper patient identification.**		
HG4.1.1	**M** Recordings and medical records are labeled with the patient's first and last name.		
HG4.1.2	**M** Recordings and medical records are labeled with a second patient identifier (e.g. date of birth, personal health number).		
HG4.1.3	**M** Recordings and medical records are labeled with the date of the test.		
HG5.0	**INTERPRETATION AND REPORTS**		
HG5.1	**Diagnostic reports are labeled in a standardized format that provides comprehensive and necessary information for clinical decision-making.** *Guidance: The final report may be a combination of the interpretation, patient questionnaire, and the test data.*		
HG5.1.1	**M** The final report includes the patient's first and last name.		
HG5.1.2	**M** The final report includes a unique personal identifier number (e.g. Personal Health Number).		

No.		Description	Reference	Change
HG5.1.3	**M**	The final report includes the date of birth.		
HG5.1.4	**M**	The final report includes the diagnostic service name.		
HG5.1.5	**M**	The final report includes the test(s) performed.		
HG5.1.6	**M**	The final report includes the name or identification of the individual scoring the test, as well as any comments made by the scorer. *Guidance: There is a mechanism in place to determine who scored the test.*		
HG5.1.7	**M**	The final report includes the name of authorized individual referring the patient for the test.		
HG5.1.8	**M**	The final report includes the name of the interpreting physician.		
HG5.1.9	**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.*		
HG5.1.10	**M**	The final report includes date of the test.		
HG5.1.11	**M**	The final report includes date of interpretation.		
HG5.1.12	**M**	Multiple page reports include patient identifiers on each sequentially numbered page.		
HG5.2		**Interpretations contain sufficient information to assist in diagnosis.** *Intent: When required, previous reports are promptly available for review and comparison with the current test. A request for diagnostic test includes relevant clinical information, a working diagnostic or pertinent clinical signs and symptoms, and may include specific clinical questions to be answered in the final report. Such information helps tailor the most appropriate diagnostic test to the clinical scenario, enhances the clinical relevance of the report, and thus promotes optimal patient care. Additionally, feedback from the patient questionnaire should be evaluated by the interpreting physician for comment or feedback.*		
HG5.2.1		Standardized report templates are used. *Guidance: The medical director is encouraged to review report templates to ensure they are clear and without ambiguity.*		
HG5.2.2	**M**	The body of the report includes the procedures performed. *Guidance: The report includes a description of the studies or procedures performed, medications, equipment used, relevant patient preparation and positioning details.*		
HG5.2.3	**M**	The body of the report includes the findings. *Guidance: The report uses appropriate anatomic**,** pathologic, and diagnostic terminology to describe the findings.*		

No.		Description	Reference	Change
HG5.2.4	**M**	The body of the report includes the potential limitations. *Guidance: The report, when appropriate, identifies factors that may compromise the test. Any known significant patient reaction or complication is recorded.*		
HG5.2.5	**M**	The body of the report includes the clinical issues or concerns. *Guidance: The report addresses or answers any specific clinical questions.*		
HG5.2.6	**M**	The body of the report includes the impression (e.g. conclusion or diagnosis) section of the report. *Guidance: Unless the report is brief, each report contains an "impression" section.*		
HG5.2.7	**M**	The body of the report includes a comparison with previous tests and reports when relevant.		
HG5.3	**A timely and accurate final report is issued for all tests.** *Intent: A final report is the definitive means of communicating test results to the authorized individual or other relevant health-care provider. Additional methods for the communication of results are encouraged in certain situations.*			
HG5.3.1	M	Final reports are issued for all tests.		
HG5.3.2		The final report is verified by the interpreting physician to minimize typographical errors, accidentally deleted words, and confusing or conflicting statements. *Guidance: The verification process can be conducted electronically.*		
HG5.3.3	M	Verified reports are signed by the reporting physician.		
HG5.3.4	M	If the content of the report is not verified by the author, it is clearly indicated on the report.		
HG5.3.5	M	If the content of the report has not been verified by the author, there is a process in place to verify the accuracy of the transcription.		
HG5.3.6	M	A copy of the final report is archived by the diagnostic service as part of the patient's medical record (paper or electronic) and is retrievable for future reference.		
HG5.3.7	M	Medical staff responsible for the patient are notified of report delays in cases that may compromise patient care.		
HG5.3.8		The use of abbreviations or acronyms is limited to avoid ambiguity.		
HG5.3.9	M	The final report does not include a blank prescription for PAP therapy. *Intent: Results and therapy options are discussed with the patient by the referring physician to ensure the best treatment options for the patient. The interpretation may include a recommendation for treatment to the referring physician.*		

No.	Description	Reference	Change
HG5.3.10	M Preliminary reports are distributed when required but are clearly identified and must be followed by a final report issued to the user.	ISO15189 5.91d	
HG5.4	**Urgent and other non-routine test findings are effectively communicated.** *Intent: Routine reporting of test findings is communicated through the usual channels established by the facility. However, in urgent or other non-routine clinical situations, the interpreting physician expedites the delivery of a diagnostic report (preliminary or final) in a manner that ensures timely receipt of the findings. Documentation of this communication is extremely important because clinical care errors may relate to flaws in the chain of communication.*		
HG5.4.1	**M** There is a written procedure on communication of urgent and other non-routine tests findings (e.g. critical findings/results). *Intent: A diagnostic service's policy on communication can be an effective tool to promote patient care. The policy 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 tests 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.*		
HG5.5	**There are policies and procedures in place to deal with corrected and addendum reports.** *Guidance: There are clear directions for staff that indicate when a corrected report or addendum report is required (this may be done through the use of examples), and the steps that must be taken when issuing a corrected or addendum report. There should be guidance as to when clinical staff should be informed of a corrected or addendum report or when a physician should be alerted about a corrected or addendum report. Clear identification that the report has been corrected or added to should be followed by the new result and then the original result.*		
HG5.5.1	**M** There are policies and procedures that address corrected and addendum reports.		
HG5.5.2	**M** Corrected and addendum reports are clearly identified.		
HG5.5.3	**M** Both the original and the new results are reported.		
HG5.5.4	**M** The date and time the change or addition was made are recorded.		

No.	Description	Reference	Change
HG5.5.5	**M** The identity of the person making the change or addition is recorded.		
HG5.5.6	**M** Notification of clinical staff is recorded when there is a significant discrepancy between the original and the corrected or addendum report.		

Home sleep apnea testing

Home sleep apnea testing (HSAT) is a valuable diagnostic tool used in the investigation of patients with a moderate to high clinical suspicion of obstructive sleep apnea (OSA). This test is routinely conducted as an ambulatory test.

No.		Description	Reference	Change
HSAT1.0	**PATIENT ORIENTATION**			
	See also Global HSAT accreditation standards HG2.0			
HSAT1.1	**Patients are orientated and prepared for the test being performed.**			
HSAT1.1.1	**M**	Patient preparation instructions are clearly communicated.		
HSAT1.1.2	**M**	Patients are orientated to their testing equipment in person, but when this cannot be achieved the reason is documented. *Guidance: The preferred method of instructions for patient set-up is in person; however, virtual teaching can be used, but must include video and the facility should follow the patient's choice.*		
HSAT1.1.3	**M**	Patients are informed of the procedure to contact staff for assistance with technical issues.		
HSAT1.1.4	**M**	Patient set-up with the equipment is conducted by qualified staff who have appropriate training and experience. Guidance: *Refer to Human Resources HHR3.1.*		
HSAT1.1.5	**M**	In-line filters are appropriately used to reduce the risk of transmission of infections.		
HSAT2.0	**HOME SLEEP APNEA TEST (HSAT)**			
HSAT2.1	**HSAT is standardized and recorded in a manner to ensure accurate results for interpretation.**			
HSAT2.1.1	**M**	Tests are only performed on patients who are suspected of having a moderate to high pretest probability of obstructive sleep apnea (OSA).	AASM CSS/CTS	
HSAT2.1.2	**M**	Tests are not used for the screening of asymptomatic patients.		

No.		Description	Reference	Change
HSAT2.1.3	**M**	Tests are not used in pediatric patients or patients where significant comorbid medical conditions exist. *Guidance: The diagnosis of OSA using HSAT testing in patients with significant comorbid conditions may degrade the accuracy of the test. Additional information for exclusion criteria can be found on the Ministry of Health standardized requisition and guidelines.*	AASM CSS/CTS GPAC/MSC Guidelines	
HSAT2.1.4	**M**	Tests are not used for patients suspected of having other sleep disorders, including central sleep apnea, periodic limb movement disorder (PLMD), insomnia, parasomnias, circadian rhythm disorders, or narcolepsy. *Intent: Other sleep disorders can impact the accuracy of the test.*	AASM	
HSAT2.1.5	**M**	The rationale for initiating HSAT testing is documented.		
HSAT2.1.6	**M**	Patients are informed of the procedure to contact staff for assistance. In the case of emergency patients should access emergency services.		
HSAT2.1.7	**M**	A medical history including a sleep questionnaire is obtained prior to interpretation.		
HSAT2.1.8	**M**	A minimum of four hours of data are obtained from all channels. *Guidance: If less than four hours of acceptable data is obtained the interpreting physician should evaluate for a repeat test.*	Advisory Panel	
HSAT2.1.9	**M**	A post-test sleep questionnaire is obtained.		
HSAT2.1.10	**M**	HSAT data is manually scored.		
HSAT2.1.11	**M**	Raw data is available to the interpreting physician for review.		
HSAT2.1.12	**M**	Previous patient recording is cleared prior to use and the device is initialized for the new test.		
HSAT2.2		**HSAT measured parameters are comprehensive and provide all the necessary information for interpretation.** *Guidance: Stand-alone microphones, thermistors and electrodes are not used as part of the diagnostic test.*		
HSAT2.2.1	**M**	Monitoring of HSAT testing includes respiratory/ventilatory effort or equivalent.		
HSAT2.2.2	**M**	Monitoring of HSAT testing includes airflow (nasal pressure or thermal device).		
HSAT2.2.3	**M**	Monitoring of HSAT testing includes heart pulse/rate.		
HSAT2.2.4	**M**	Monitoring of HSAT testing includes SpO_2% (oxygen saturation).		
HSAT2.2.5		Monitoring of HSAT testing includes body position.		
HSAT2.2.6		Monitoring of HSAT testing includes snoring.		

Analysis and scoring for HSAT

No.		Description	Reference	Change
HSAT2.3	**Analysis of test data is conducted in a way that ensures meaningful, relevant, and accurate data are reported.**			
HSAT2.3.1	M	HSAT data is scored manually by a RPSGT.		
HSAT2.3.2	M	The procedural manual includes documented definitions used to describe all respiratory events.	AASM	
HSAT2.3.3	M	The medical director or interpreting physician evaluates abnormal findings, and recommendations are communicated to the referring physician.		
HSAT2.4	**Scoring of test data is conducted in a way that ensures meaningful, relevant, and accurate data are reported.**			
HSAT2.4.1	**M**	Scoring of HSAT includes hypopneas.	AASM Scoring Manual V 2.6	
HSAT2.4.2	**M**	Scoring of HSAT includes apneas. *Guidance: Careful consideration should be taken when scoring apneas. In the event of an identified apnea the scorer should support their findings with comments.*	AASM Scoring Manual V 2.6	
HSAT2.4.3		Scoring of HSAT includes the type of apnea (e.g. obstructive, central and mixed apneas).		
HSAT2.4.4	**M**	If Cheyne-Stokes breathing is identified by the scorer, it is noted in the comments.	AASM Scoring Manual V 2.6	
HSAT2.4.5	**M**	Scoring of HSAT includes artifact.	AASM Scoring Manual V 2.6	
HSAT2.4.6	**M**	Scoring of HSAT includes loss of signal.	AASM Scoring Manual V 2.6	
HSAT2.4.7	**M**	Scoring of HSAT includes oxygen saturation.	AASM Scoring Manual V 2.6	

Technical summary for HSAT

No.		Description	Reference	Change
HSAT2.5	**Technical summary is standardized in a way that ensures meaningful, relevant, and accurate data are reported.**			
HSAT2.5.1	**M**	Type of recording device.	AASM Scoring Manual V 2.6	
HSAT2.5.2	**M**	Total recording time. *Intent: Total recording time includes identified artifact and awake periods.*	AASM Scoring Manual V 2.6	
HSAT2.5.3	**M**	Total analysis time for airflow and oxygen saturation (hr:min).	AASM Scoring Manual V 2.6	

No.		Description	Reference	Change
HSAT2.5.4		Number of snoring events.	AASM Scoring Manual V 2.6	
HSAT2.5.5	**M**	Number of hypopneas.	AASM Scoring Manual V 2.6	
HSAT2.5.6	**M**	Number of obstructive and central apneas.	AASM Scoring Manual V 2.6	
HSAT2.5.7	**M**	Apnea Hypopnea Index (AHI). *Guidance: RDI and REI should not be reported because they are derived numbers.*	AASM Scoring Manual V 2.6	
HSAT2.5.8	**M**	Heart rate (average, highest, lowest).	AASM Scoring Manual V 2.6	
HSAT2.5.9	**M**	Oxygen desaturation index (ODI) is derived from monitoring time.	AASM Scoring Manual V 2.6	
HSAT2.5.10	**M**	Oxygen saturation (mean, maximum, minimum).	AASM Scoring Manual V 2.6	
HSAT2.5.11	**M**	Oxygen saturation % time $\leq$ 88% or other thresholds as defined by the diagnostic service.	AASM Scoring Manual V 2.6	
HSAT2.5.12	**M**	Technical comments are reported by the scorer to provide additional relevant information to the interpreting physician.	AASM Scoring Manual V 2.6	

HSAT3.0 POSITIVE AIRWAY PRESSURE (PAP)

PAP therapy is a specialized treatment for the management of sleep-related disorders including obstructed sleep apnea. Health-care professionals require additional training to treat patients using PAP therapy. PAP therapy should be only assigned to qualified and trained individuals by a qualified physician.

HSAT3.1		PAP protocols are standardized in a manner that ensures appropriate patient therapy.
HSAT3.1.1	**M**	PAP therapy is not initiated without a prescription from a qualified physician.
HSAT3.1.2	**M**	Responsibilities for PAP therapy are assigned to qualified staff by the medical director. *Guidance: A qualified individual should have a health-care background and appropriate training in PAP therapy.*
HSAT3.1.3	**M**	The patient is given instructions on how to use the equipment.
HSAT3.1.4	**M**	There is a documented protocol for patient follow-up.
HSAT3.1.5	**M**	Patient follow-up notes are documented in the patient's medical record.

No.		Description	Reference	Change
HSAT3.1.6	**M**	Patient follow-up is scheduled at defined intervals. *Intent: The initial follow-up should be within one to two weeks of equipment application.*		
HSAT3.1.7	**M**	There is a documented mechanism to evaluate patient compliance. *Intent: There is a system in place that objectively measures PAP percentage compliance (e.g. review data download), and clinical response (e.g. evaluating patient symptoms and diagnostic parameters).*		
HSAT3.1.8	**M**	All factors are considered to achieve optimal PAP pressure. *Guidance: Information from the data download and patient follow up will help guide appropriate equipment settings.*		
HSAT3.1.9	**M**	Mask fitting is assessed prior to initiating therapy to ensure minimal leaks and optimal patient comfort (e.g. mask fitting guide).		
HSAT3.1.10	**M**	There is a documented protocol on what parameter(s) can be changed.		
HSAT3.1.11	**M**	A change in modality (e.g. change from CPAP to BIPAP/ASV) or alternative therapy (e.g. oral appliance) is not conducted without a physician's order.		
HSAT3.1.12	**M**	Changes in parameters or modality are documented in the patient's medical record.		
HSAT3.1.13	**M**	The diagnostic service develops and maintains the delivery of scheduled progress reports to the referring physician. *Guidance: The facility communicates progress reports to the referring physician to provide an update on PAP therapy compliance.*		
HSAT3.1.14	**M**	Templates for progress reports are approved by the medical director. Guidance: At a minimum, a *progress report should include compliance data, mask leak, evidence of residual sleep disorder breathing and overnight oximetry on CPAP.*		
HSAT3.1.15	**M**	Management guidelines for CPAP titration are defined, documented and approved by the medical director.	AASM	
HSAT3.1.16	**M**	Advanced PAP therapy modalities (e.g. BiPAP, ASV, AVAPS, iVAPS) are approved by the medical director before application. *Guidance: Advanced PAP therapy should only be considered when patients have undergone a level one polysomnogram and a consultation by a specialist in sleep medicine. Only those specialists should issue prescriptions for these advanced modalities.*	GPAC/MSC Guidelines	
HSAT3.1.17	**M**	Management guidelines for advanced PAP therapy modalities are defined, documented and approved by the medical director.	AASM	

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.

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.

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.

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…)

College The term refers to the College of Physicians and Surgeons of BC.

confidentiality Guaranteed limits on the use and distribution of information collected from individuals or organizations.

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**.

disinfectant A chemical agent that kills most disease-producing microorganisms, but not necessarily bacterial spores. Disinfectants are applied to only inanimate objects. Some combine a cleaner with a disinfectant.

high-level disinfection (HLD)	A process capable of killing vegetative bacteria, mycobacteria (including mycobacterium tuberculosis, fungi, and lipid and nonlipid viruses), as well as some, but not necessarily high numbers of, bacterial spores.
human resources	The personnel requirements of the organization.
HSAT diagnostic facility	An HSAT facility is defined as any facility or individual that offers HSAT diagnostic services to any individual residing within the province of BC.
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.
low-level disinfection (LLD)	A process capable of killing most vegetative bacteria and some fungi, as well as enveloped (lipid) viruses (e.g. influenza, hepatitis B and C, and HIV). LLDs do not kill mycobacteria, non-enveloped viruses, or bacterial spores.
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 failure to obtain accreditation.
manufacturer's instruction for use (MIFU)	The written directions provided by the manufacturer or distributor of a product that contain the necessary information for the safe and effective use of the product. For information regarding reprocessing steps always follow the MIFU for the medical device, cleaning agents and disinfectants (low-level and high-level) to ensure compatibility. Individual medical device manufacturers should provide detailed information on which disinfectants are compatible and should be prepared to provide further product testing upon request.
medical device	Any instrument, apparatus, appliance, material, or other article, whether used alone or in combination, intended by the manufacturer to be used for human beings for the purpose of: diagnosis, prevention, monitoring, treatment or alleviation of disease, injury or handicap; investigation, replacement, or modification of the anatomy or of a physiological process; or control of conception.
medical director	A physician who is registrant with the College and whose credentials are acceptable to the DAP Committee. Also is responsible for all matters pertaining to the procedures and medical care in the diagnostic service.
non-critical devices	Devices that either touches only intact skin (but not mucous membranes) or do not directly touch the client/patient/resident. Reprocessing of non-critical devices involves cleaning and may also require low-level disinfection (e.g. blood pressure cuffs, stethoscopes).
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.
safety	The degree to which the potential risk and unintended results are avoided or minimized.
semi-critical devices	Devices that come in contact with mucous membranes or non-intact skin, but ordinarily do not penetrate them. Reprocessing semi-critical devices involves meticulous cleaning followed by high-level disinfection (the type of disinfection required depends on the item).
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).

References

American Academy of Sleep Medicine. *Practice Guidelines*. aasm.org

Baldridge National Quality Program. 2009-2010. *Health Care Criteria for Performance Excellence*. Maryland, USA.

British Columbia Medical Quality Initiative. Provincial Privileging Dictionaries. Retrievable at: http://bcmqi.ca/privileging-dictionaries/

Canadian Council on Health Service Accreditation. 2009. *Patient Safety Goals*. 2009.

Canadian Patient Safety Institute. Safer Healthcare Now! Retrieved from http://www.saferhealthcarenow.ca/EN/Pages/default.aspx

Canadian Patient Safety Institute. October 2003. *The Canadian Patient Safety Dictionary*. Ontario, Canada.

Canadian Patient Safety Institute. Revised August 2009. *The Safety Competencies: Enhancing Patient Safety across Health Professions*, 1st ed. Ontario, Canada.

Canadian Sleep Society. https://css-scs.ca/

Canadian Thoracic Society. https://cts-sct.ca/

Clinical Audit Manual. Nancy Dixon and Mary Pearce for Healthcare Quality Quest, 2008. Hampshire, UK.

College of Physicians and Surgeons of British Columbia. Practice Standard. 2019. *Promotion and Sale of Medical Supplies and Devices.* Retrieved from: https://www.cpsbc.ca/files/pdf/PSG-Promotion-Sale-Medical-Supplies-Devices.pdf

Freedom of Information and Protection of Privacy Act (BC Laws). Retrieved from: https://www.bclaws.ca/civix/document/id/complete/statreg/96165_00

Government of Canada. 2002. *Patient's Bill of Rights – A Comparative Overview* [PRB 01-31E]. Retrieved from http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/BP/prb0131-e.htm

Government of Canada. Disclosing a Conflict of interest. Retrieved from https://www2.gov.bc.ca/assets/gov/careers/about-the-bc-public-service/ethics/conflict_interest_guidelines_employees.pdf

Government of British Columbia. Guideline and Protocol Advisory Committee: Retrieved from: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/committees/guidelines-and-protocols-advisory-committee-gpac

Health Canada. Medical Devices Active License Listing (MDALL). Retrievable from: http://www.hc-sc.gc.ca/dhp-mps/md-im/licen/mdlic-eng.php

Health Care (Consent) and Care Facility (Admission) Act [RSBC 1996] Chapter 181. Retrieved from: http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96181_01

Healthcare Commission. *Criteria for Assessing Core Standards in 2008/09*. UK

Infection Prevention and Control (IPAC) Canada. Cleaning and Disinfection of non-critical multi-use equipment and devices in Community Setting Position Statement. January 2018. https://ipac-canada.org/photos/custom/Members/pdf/17Jan_Cleaning%20NonCrit%20Equip%20Comm%20Position%20Statement_revised_Jan2018_final.pdf

International Society for Quality in Health Care (ISQUA). 2007. *International Accreditation Standards for Healthcare External Evaluation Organizations, 3rd ed.* Dublin, Ireland.

Joint Commission 2009 Hospital Accreditation Standards. Illinois, USA.

Joint Commission 2009 Hospital Accreditation Standards. The *Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery: Guidance for Healthcare Professionals*. Illinois, USA.

Ministry of Justice of British Columbia. BC Limitation Act, 2013. http://www.ag.gov.bc.ca/legislation/limitation-act/2012.htm

Occupational Health and Safety Regulations of British Columbia.

Quest for Quality in Canadian Health Care: Continuous Quality Improvement, 2nd Edition. MaryLou Harrigan for Health Canada.

WorkSafe BC publications accessible through. www.worksafebc.com/publications.

WorkSafe BC Laboratory Health and Safety Handbook, 2008

World Health Organization. Improved Hand Hygiene to Prevent Healthcare – Associated Infections. May 2007, Volume 1, Solution 9. Geneva, Switzerland.

World Health Organization. Patient Identification. May 2007, Volume 1, Solution 2. Geneva, Switzerland.