COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

Diagnostic Accreditation Program

ACCREDITATION STANDARDS

Patient Safety

Diagnostic Accreditation Program
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Introduction

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 a continuous effort is made to improve patient safety. Appropriate and sufficient resources should be allocated to support the diagnostic service's implementation of the patient safety priorities or goals.

Patient safety

No.		Description	Risk	Reference	Change
SPS1.0		**THE DIAGNOSTIC SERVICE CREATES A CULTURE OF PATIENT SAFETY AND MAKES PATIENT SAFETY A PRIORITY.**			
SPS1.1		**The diagnostic service demonstrates that patient safety is a core priority.**			
SPS1.1.1	**B**	A patient safety program is implemented involving the staff of the diagnostic service.			
SPS1.1.2	**B**	The patient safety program is reviewed on a regular basis and new information is incorporated when appropriate.			
SPS1.1.3	**B**	Staff are aware of and are able to demonstrate their responsibilities relative to patient safety.			
SPS1.1.4	**B**	Patient safety targets are established by the diagnostic service and performance is reviewed and reported on regularly.			
SPS1.1.5	**B**	Patient safety data is reviewed and used to improve patient safety.			
SPS1.2		**The activities of the diagnostic service ensure patient safety.**			
SPS1.2.1	**B**	Mechanisms are available for staff to identify, provide feedback on, and communicate openly about patient safety issues and concerns.			
SPS1.2.2	**M**	There is a process for patients and their advocates to report concerns related to patient safety.	M		
SPS1.2.3	**M**	There are systems in place to ensure that patient safety notices, alerts and other information is communicated.	M		
SPS1.2.4	**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. tourniquets, gloves, bandages).*	M		
SPS1.2.5	**M**	All patient safety issues are documented and investigated.	M		

Patient identification

No.		Description	Risk	Reference	Change
SPS2.0		**POSITIVE PATIENT IDENTIFICATION PRECEDES COMMENCEMENT OF THE TEST OR PROCEDURE.**			
SPS2.1		**Patient identification is confirmed prior to a patient's test or procedure by the individual(s) performing the test or procedure.**			
SPS2.1.1	**M**	Patients are involved in the identification process to the fullest extent possible.	H		
SPS2.1.2	**M**	Patient identification is confirmed prior to testing by the person(s) performing the test.	C	Joint Commission	
SPS2.1.3	**M**	At least two unique patient identifiers are used when verifying patient identification.	C		
SPS2.1.4	**M**	In-patients are identified with a wristband or service-approved alternative procedure.	H		
SPS2.1.5	**M**	Staff confirm the information on the wristband is consistent with verbal information provided by the patient.	H		
SPS2.1.6	**M**	Pediatric and other patients who cannot provide identification information are identified by a responsible adult.	H		
SPS2.1.7	**M**	Patient identity discrepancies are resolved prior to testing.	H		
SPS2.1.8	**B**	There is a documented process to resolve any clinically relevant patient demographic ambiguities in a confidential and respectful manner.		GSSO	New
SPS2.2		**There are methods in place to address situations where the identity of the patient is unknown.**			
SPS2.2.1	**M**	An emergency identification method is used when the patient's identity is unknown. *Guidance: This may contain an alias name and a unique ID number such as a medical record number.*	H		
SPS2.2.2	**M**	The temporary patient identification is attached to the patient, and affixed on patient tracings, as applicable.	H		

No.		Description	Risk	Reference	Change
SPS2.2.3	**M**	The temporary patient identification is cross-referenced with the patient's name and unique ID number when that name and number becomes known.	H		

Medication management and administration

No.		Description	Risk	Reference	Change
SPS3.0		**THE DIAGNOSTIC SERVICE HAS METHODS IN PLACE TO ENSURE THAT MEDICATION IS MANAGED AND ADMINISTERED TO PATIENTS SAFELY AND EFFECTIVELY.**			
SPS3.1		**Medications are stored and disposed of safely.**			
SPS3.1.1	**M**	Storage of medications complies with manufacturer's recommendations.	H		
SPS3.1.2	**M**	All stored medications are labeled with the contents, expiration date, and any warnings as applicable.	H		
SPS3.1.3	**M**	The diagnostic service regularly inspects all medication storage areas and medications.	M		
SPS3.1.4	**M**	All medications are disposed of using appropriate disposal methods.	M		
SPS3.2	**B**	The diagnostic service ensures that all medications are labeled.			
SPS3.2.1	**M**	Medication containers are labeled with the medication name, strength and quantity when medications are prepared but not administered immediately.	H		
SPS3.2.2	**M**	All medications are labeled with the date prepared.	H		
SPS3.2.3	**M**	Medications are labeled with an expiration date and when not administered within 24 hours, or when the expiration occurs in less than 24 hours.	H		
SPS3.2.4	**M**	Any unlabeled medication containers are discarded immediately.	H		
SPS3.3		**The appropriateness of all medication orders is reviewed.**			
SPS3.3.1	**M**	Only authorized staff request medications. *Guidance: There is a facility policy that defines "authorized individual" that includes medical physicians and other designated health professionals as permitted by governing legislation, rules and bylaws.*	H		
SPS3.3.2	**M**	Medication orders are reviewed for possible patient allergies or sensitivities.	H		
SPS3.3.3	**M**	Medication orders are reviewed for the appropriateness of the dose, frequency, and route of administration.	H		

No.		Description	Risk	Reference	Change
SPS3.3.4	**M**	Medication orders are reviewed for potential contraindications and adverse interactions.	C		
SPS3.3.5	**M**	All concerns, issues, or questions related to the appropriateness of a medication order are resolved with the prescriber or staff involved with the patient's care or services prior to administration.	C		
SPS3.4		**Medications are administered safely.**			
SPS3.4.1	**M**	Only medical practitioners and authorized staff obtain and administer medication.	C		
SPS3.4.2	**M**	Patient identity is verified prior to medication administration.	H		
SPS3.4.3	**M**	There is a process in place to ensure that the correct medication is selected prior to administration.	H		
SPS3.4.4	**M**	Prior to administration, the medication is visually inspected for colour, clarity and expiration date.	H		
SPS3.4.5	**M**	There is a process in place to ensure the individual administering the medication verifies that the medication is administered at the proper time, in the prescribed dose, and by the correct route to the correct patient.	M		
SPS3.5		**Patients are monitored to ensure that medication(s) have been administered safely and effectively.**			
SPS3.5.1	**M**	Patients are monitored to assess the effectiveness of the medication(s) administered to them.	H		
SPS3.5.2	**M**	Patients are monitored for any potential side effects or adverse reactions resulting from medication administration.	H		
SPS3.5.3	**M**	Staff know how to respond to adverse drug events, significant drug reactions, and medication errors.	H		
SPS3.5.4	**M**	Processes are in place to ensure the safety of patients prior to discharge or release from the diagnostic service after receiving medications. *Guidance: An example of this would be for patients who have been administered a mild sedative for a procedure (e.g. Ativan). Prior to the patient being discharged, the diagnostic service should ensure that the patient has a safe way of getting home.*	H		
SPS3.5.5	**M**	Prior to discharge from the diagnostic service, the patient is monitored for a sufficient amount of time to ensure readiness for discharge.	H		

No.		Description	Risk	Reference	Change
SPS3.5.6	**M**	Readiness to discharge is documented in the medical record.	H		

Adverse events and critical incidents

No.		Description	Risk	Reference	Change
SPS4.0		**ADVERSE EVENTS AND CRITICAL INCIDENTS, INCLUDING NEAR MISSES ARE MANAGED APPROPRIATELY.**			
SPS4.1		**There are policies, procedures and practices for managing adverse events and critical incidents.**			
SPS4.1.1	**B**	Definitions of adverse events, critical incidents and near misses applicable to the diagnostic service are communicated to all staff.			
SPS4.1.2	**M**	Policies, procedures and practices for addressing adverse events and critical incidents are documented and available to all staff.	M		
SPS4.1.3	**M**	All adverse events and critical incidents are documented.	H		
SPS4.1.4	**M**	Policies and procedures for reporting, investigating and making recommendations following a near miss are documented and available to staff.	M		
SPS4.1.5	**B**	There is a systematic process to investigate adverse events and critical incidents to determine multiple underlying contributing factors. *Guidance: The investigation process is appropriate for the magnitude of the problem and risk to patient or staff safety.*			
SPS4.1.6	**B**	There are policies, procedures and practices for disclosing information to patients following an adverse event and/or critical incident.			
SPS4.1.7	**B**	Staff know whom to contact for advice or direction and are aware of their role during an adverse event or critical incident.			
SPS4.1.8	**B**	There is a defined process for reporting an adverse event or critical incident to the administration of the organization and to outside organizations.			
SPS4.1.9	**B**	Support and counseling are available to patients, their families and staff following an adverse event or critical incident.			
SPS4.2		**There is a process to determine and manage the medical significance of adverse events and critical incidents.**			
SPS4.2.1	**M**	All reported adverse events and critical incidents are immediately assessed by appropriate technical and medical staff to determine medical significance.	H		

No.		Description	Risk	Reference	Change
SPS4.2.2	**M**	The referring practitioner is informed in cases of medical significance.	H		
SPS4.2.3	**B**	Appropriate technical and medical staff assesses indications for halting further tests and authorizing resumption.			
SPS4.2.4	**B**	Medical staff assess indications for withholding diagnostic reports and review already released reports for potential recall.			
SPS4.3		**Recommendations following an adverse event or critical incident are implemented to decrease the likelihood of recurrence.**			
SPS4.3.1	**B**	There are mechanisms in place for management to regularly track and trend aggregate data collected through the reporting process.			
SPS4.3.2	**M**	Changes made to the diagnostic service's systems and processes to prevent recurrence are documented.	M		
SPS4.3.3	**B**	Recommendations and changes implemented are communicated to relevant staff.			
SPS4.3.4	**B**	Changes implemented are continuously monitored and evaluated to ensure effectiveness.			

Medical emergencies

No.		Description	Risk	Reference	Change
SPS5.0		**THE DIAGNOSTIC SERVICE HAS PROCEDURES IN PLACE TO HANDLE MEDICAL EMERGENCIES.**			
SPS5.1		**There are procedures to handle medical emergencies in a timely and effective manner.**			
SPS5.1.1	**M**	There is a medical emergency response procedure in place.	C		
SPS5.1.2	**M**	Staff are familiar with the procedure(s) for responding to medical emergencies.	H		
SPS5.1.3	**M**	The facility identifies staff who respond to emergencies and provides training in the use of emergency equipment.	H		
SPS5.1.4	**M**	Emergency call systems are available in-patient care areas. *Guidance: Facilities should conduct a risk assessment to determine if and what emergency call systems are required (e.g. unattended patients, high-risk procedures, etc.).*	H		
SPS5.1.5	**M**	Staff know how to access emergency medical services.	H		
SPS5.1.6	**M**	Staff know how to access emergency equipment and supplies.	H		
SPS5.1.7	**B**	The facility has a process to ensure that there is access to an automated external defibrillator (AED) or an on-site emergency response team.		AASM 2025 (S-7)	New

References

Abbreviation	Reference
AASM 2025	American Academy of Sleep Medicine. AASM Standards for Accreditation. Updated January 2025.
GSSO	Government of British Columbia. Gender, Sex, and Sexual Orientation [Internet]. Victoria (BC): Government of British Columbia; [cited 2024 Aug 9]. Available from: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/health-information-standards/standards-catalogue/gender-sex
Joint Commission	American College of Surgeons. Joint Commission publishes 2018 National Patient Safety Goals. Bull Am Coll Surg. 2018 Feb [cited 2024 Aug 9]. Available from: https://www.facs.org/for-medical-professionals/news-publications/news-and-articles/bulletin/2018/02/joint-commission-publishes-2018-national-patient-safety-goals/