COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

DIAGNOSTIC ACCREDITATION PROGRAM

T 604-733-7758
TF 1-800-461-3008
F 604-733-3503

300–669 Howe Street
Vancouver BC V6C 0B4
Canada

cpsbc.ca

ACCREDITATION STANDARDS REVISION RECORD

Polysomnography

New categories

The following categories have been updated to new chapters.

Version 1.2	Version 2.0
Governance and leadership	**New** Governing Body
Medical staff	**New** • Medical Director • Medical Staff Qualifications and Requirements • Delegated Medical acts
Human Resources	**New** • Staff Administration, Management and Development • Polysomnography Technical Staff Requirements and Scoring
Information Management	**Revised (extracted from information management)** Document Control

Polysomnography

The entire category of polysomnography has been updated to be separated into each scope of service:

Version 1.2	Version 2.0
Polysomnography	**New** • Adult Polysomnography • Pediatric Polysomnography • Positive Airway Pressure Titration and Adjunct Therapies • Daytime Testing • Ambulatory Testing • Home Sleep Apnea Testing • Positive Airway Pressure Therapeutics

Patient and client focus

No.	Version 1.2		Version 2.0	
SPC1.1.3		Cultural and spiritual sensitivities of patients and clients are acknowledged and respected without compromising quality or safety.		**Revised** The patient's cultural and spiritual preferences are respected.
SPC1.1.4				**New** Adaptions to examinations are considered to accommodate a cultural or spiritual practice, without compromising quality and safety. *Guidance: Service users work collaboratively with patients to review adaption options and limitations.*
SPC1.2.1	**M**	The time from referral to the test is defined and monitored.	**M**	**Revised** The time from referral to the test is defined, monitored and communicated to the medical director.
SPC1.3.1		Interpreting physicians are responsive to case specific or procedural inquiries.	**M**	**Revised** Interpreting physicians are responsive to case-specific or procedural inquiries.
SPC2.2.1		Patients and clients are informed of the process to register complaints and feedback.	**M**	**Revised** Patients and clients are informed of the process to register complaints and feedback.

No.	Version 1.2	Version 2.0	
SPC2.2.2	There are methods to identify complaints within the patient and client satisfaction data that require specific action.	**M**	**Revised** There are methods to identify complaints that require specific action.
SPC2.2.3	There is a procedure for documenting complaints from patients and clients.	**M**	**Revised** There is a procedure for documenting complaints from patients and clients.
SPC2.2.4	Responses to patient and client inquiries and complaints are addressed promptly and effectively.	**M**	**Revised** Responses to patient and client inquiries and complaints are addressed and monitored in a defined time frame.
SPC2.2.5	The resolution of complaints is documented.	**M**	**Revised** The resolution of complaints is documented.
SPC2.2.6	Information gained from complaints is used to make improvements as necessary.	**M**	**Revised** Information gained from complaints is used to make improvements.
SPC2.2.7			**New** The complaint process is made available to the public. *Guidance: This information may be on the facility or organization's website or on the requisition.*
SPC2.3			**New** There is a process in place to gather feedback from referring physicians.
SPC2.3.1		**M**	**New** There is a documented procedure to obtain feedback from referring physician(s) on an annual basis.
SPC2.3.2		**M**	**New** There is a process to review feedback by the medical director.
SPC2.3.3		**M**	**New** Feedback obtained from referring physicians is used to make improvements.

General safety

No.	Version 1.2		Version 2.0	
SSA1.3.2	**M**	Minutes of the last three safety committee meetings are posted.	**M**	**Revised** Minutes of the last three safety committee meetings are available for review.
SSA2.1.1		Inspections by external authorities (e.g. Fire Marshall, WorkSafeBC, building inspections) are performed and maintained. *Guidance: New facilities should maintain a copy of the occupancy permit as issued by a building inspector.*	**M**	**Revised** Records or outcomes of inspections by external authorities are performed and maintained (e.g. fire and safety audits, occupancy permit).
SSA2.5.3		Washrooms are conveniently located and separate from patient washrooms. Guidance: WorkSafeBC guideline G4.85(1)-1 recommends that separate male and female washrooms are provided when there are more than 9 workers.	**M**	**Revised** Patient and staff washrooms are clean, conveniently located and accessible.
SSA2.6.1	**M**	There are clearly labeled hand washing sinks.	**M**	**Revised** There are clearly labeled hand washing sinks or other accessible forms of hand hygiene products available for use.
SSA2.7.2	**M**	Emergency lighting is available in the event of power failure. *Guidance: Emergency lighting units must be tested regularly.*	**M**	**Revised** Emergency lighting is available in the event of power failure.

Patient safety

No.	Version 1.2		Version 2.0	
SPS2.1.8			**M**	**New** There is a documented process to resolve any clinically relevant patient demographic ambiguities in a confidential and respectful manner.

Infection prevention and control

No.	Version 1.2		Version 2.0	
SIPC2.1.1	**M**	Hand hygiene is performed with plain soap and running water, or alcohol-based hand rubs.	**M**	**Revised** Hand hygiene is performed with plain soap and running water, or alcohol-based hand rubs. *Guidance: A sufficient amount of product is applied to ensure that all parts of the hands and wrist are rubbed. 70% to 90% of alcohol-based hand rub product is used throughout the facility.*
SIPC2.1.9				**New** Hand hygiene audits are conducted regularly.
SIPC4.2		Mechanisms are in place to ensure staff have current up to date immunizations or are aware of their previous infectious disease medical history.		**Deleted**
SIPC4.2.1		All staff are aware of and have documentation of their vaccination history, medical history, or serologic test results.		**Deleted**
SIPC4.2.2	**M**	Staff that have the potential to be exposed to blood and body fluids are offered the Hepatitis B vaccination. *Guidance: WorkSafeBC requires the Hepatitis B vaccination series be offered to employees with "occupational exposure to blood borne pathogens." Occupational exposure is defined as reasonably anticipated contact.*	**M**	**Deleted**
SIPC6.1.6			**M**	**New** Housekeeping staff are evaluated to ensure the practice of appropriate cleaning procedures is used. *Guidance: Staff designated for routine cleaning procedures may be in-house or outsourced. It is ensured that outsourced staff have appropriate training for environmental cleaning practices.*

No.	Version 1.2	Version 2.0
SIPC6.1.7		**M** **New** There is a process in place to ensure any contracted cleaning services are in conformance with current standards and best practices.
SIPC6.1.8		**M** **New** Environmental cleaning audits are conducted at least annually and as needed. *Guidance: Environmental cleaning audits may include documented visual inspections and focus on the cleanliness of the environment.*
SIPC7.0		**New** **MEDICAL DEVICE REPROCESSING**
SIPC7.1		**New** The diagnostic service reduces the risk of infections associated with medical devices.
SIPC7.1.1		**M** **New** Dirty equipment is handled, stored and transported in a safe manner to reduce the risk of exposure and is placed in an appropriate receptacle after use.
SIPC7.1.2		**M** **New** Staff assigned to reprocessing medical devices have completed training in reprocessing.
SIPC7.1.3		**M** **New** Clean equipment is stored in a manner to prevent contamination and is safeguarded from harm until the point of use.
SIPC7.1.4		**M** **New** Routinely used patient testing equipment (e.g. tourniquets) are cleaned or discarded between patients.

No.	Version 1.2	Version 2.0
SIPC7.1.5		**M** **New** Manufacturer's instructions for use must be followed when reprocessing any multi-use reusable device. *Guidance: Staff have access to the manufacturer's instructions for use for all medical devices.*
SIPC7.2		**New** Single-use medical devices are used for diagnostic or treatment purposes, where available.
SIPC7.2.1		**M** **New** When available, single-use medical devices are used.
SIPC7.2.2		**M** **New** When available, single-use non-critical medical devices are used. *Guidance: 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).*
SIPC7.2.3		**M** **New** When available, single use semi-critical medical devices are used. *Guidance: 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).*
SIPC7.2.4		**M** **New** Single-use medical devices are not reprocessed. *Guidance: Single-use (disposable) medical devices are not intended to be reused, reprocessed, or used on another patient.*
SIPC7.2.5		**M** **New** If a medical device's details are unavailable or are inappropriately labeled, it should be considered single use only.

No.	Version 1.2		Version 2.0
SIPC7.2.6			**New** Mask fitting sizing tools are single-patient use only (e.g. sizing guides).
SIPC7.3			**New** In health authority-based facilities, multi-use medical devices used for diagnostic or treatment purposes have standardized reprocessing practices.
SIPC7.3.1		**M**	**New** The facility defines what multi-use medical devices are subject to HLD (e.g. mask, hose, humidifier).
SIPC7.3.2		**M**	**New** All reusable semi-critical medical devices follow manufacturers' recommendations for reprocessing.
SIPC7.3.3		**M**	**New** Medical devices are reprocessed in accordance to the health-authority's medical device reprocessing department.
SIPC7.4			**New** In privately based facilities, multi-use medical devices used for diagnostic or treatment purposes use standardized reprocessing practices for HLD (high-level disinfection).
SIPC7.4.1		**M**	**New** The facility clearly defines which multi-use medical devices are subject to reprocessing using HLD practices (e.g. mask, hose, humidifier chamber).
SIPC7.4.2		**M**	**New** All reusable semi-critical medical devices are reprocessed following manufacturers' written instruction for reprocessing.
SIPC7.4.3		**M**	**New** The facility communicates to the DAP if they are conducting HLD practices.

No.	Version 1.2	Version 2.0
SIPC7.4.4		**M** **New** Facilities conducting HLD practices are subject to an external audit as defined by the DAP.
SIPC8.0		**M** **New** **LINEN CLEANING**
SIPC8.1		**M** **New** Laundry equipment use is conducted in a safe and effective manner to ensure appropriate linen hygiene practices.
SIPC8.1.1		**M** **New** Laundry equipment is maintained in a clean and dedicated area.
SIPC8.1.2		**M** **New** Policies and procedures are in place indicating the frequency and method of cleaning.
SIPC8.1.3		**M** **New** Manufacturers' recommendation for laundry detergent and water temperature requirements are considered prior to cleaning.
SIPC8.1.4		**M** **New** Linen is cleaned after patient use.
SIPC8.1.5		**M** **New** There is a dedicated area for housing soiled linen.
SIPC8.1.6		**M** **New** Clean linen is located in a safe and separate area from dirty linen.
SIPC8.1.7		**M** **New** No soiled linen is taken outside from the facility to a personal residence for cleaning.
SIPC8.1.8		**M** **New** If laundry services are outsourced, then the medical director is responsible for sign-off on its use.

No.	Version 1.2	Version 2.0
SIPC8.1.9		**M** **New** Linen cleaning audits are performed at least twice a year and as needed.

Quality improvement

No.	Version 1.2	Version 2.0
SQI2.1.1	**M** Key operational processes that can impact the quality of service are identified.	**M** **Revised** Key operational processes that can impact the quality of service are identified (e.g. patient wait times, report turn-around time, etc.).
SQI2.2	Clinical processes and procedures are defined and documented. *Guidance: Clinical processes are specific processes that directly impact the patient's care. Examples of clinical processes include tracing/scoring review and test interpretation.*	**Deleted**
SQI2.2.1	**M** Clinical processes and procedures that can impact quality of service are identified.	**Deleted**
SQI2.2.2	Identified processes and procedures are documented through flowcharting and/or written procedures or protocols.	**Deleted**
SQI3.1.1	**M** Clinical processes and procedures that can impact the quality of service are identified.	**M** **Revised** Clinical processes and procedures that can impact the quality of service are identified (e.g. medication administration, safety incidents, etc.).
SQI4.2.1	**M** A defined number of cases and reports are randomly selected for medical peer review for each interpreting physician on a semiannual basis. *Guidance: At a minimum, the peer review program includes the retrospective review of 10-12 physician studies per year. The type of examinations reviewed reflects the scope of service provided.*	**M** **Revised** A defined number of cases and reports are randomly selected for medical peer review for each interpreting physician on an annual basis. *Guidance: The peer review program includes the retrospective review of 10 to 12 physician studies per year. The type of examinations reviewed reflects the scope of services provided.*

No.	Version 1.2	Version 2.0
SQI5.1.1	**M** Indicators are developed to monitor the quality and safety of the diagnostic service.	**Revised** Indicators are developed to monitor the quality and safety of the diagnostic service.

Information management

No.	Version 1.2	Version 2.0
SIM5.2.1	**M** There are policies and procedures for reporting and reconciling of data entry errors and patient identification issues.	**M** **Revised** There are policies and procedures for reporting and reconciling incorrect patient data and notifying affected users. *Guidance: Incorrect patient data may be the result of data entry errors, patient and examination misregistration, incorrect examination type, incorrect patient registration, etc. Users who may have viewed or acted upon incorrect patient data must be notified. This notification should be documented.*
SIM5.2.3	**M** Audits are performed to identify the individuals who have viewed incorrect patient information. *Guidance: Follow-up notification should be provided to alert individuals that they have viewed incorrect patient information. This notification should be documented.*	**Deleted**
SIM5.2.5		**New** There is a process to investigate breeches in and or unauthorized access of confidential patient data.
SIM6.0	**THE DIAGNOSTIC SERVICE DEFINES AND MAINTAINS PROCEDURES TO CONTROL KEY OPERATIONAL DOCUMENTS.**	**Relocated** This section of standards has been relocated as its own category of standards: Document Control.

Equipment and supplies

No.	Version 1.2		Version 2.0	
SES1.1.9			**M**	**New** The facility ensures that all medical devices used for diagnostics testing are Health Canada approved.
SES1.3.12	**M**	Grounding and current leakage of all instruments connected directly to the patient are periodically tested. *Guidance: It is recommended that testing for grounding and current leakage of all the instruments be performed quarterly.*	**M**	**Relocated to SES2.3.2**
SES1.3.13			**M**	**New** The facility defines end-of-life cycle and replacement schedule for equipment.
SES2.1.1	**M**	New, replaced, or relocated equipment has safety testing performed prior to clinical use	**M**	**Revised** New or refurbished equipment has safety testing performed prior to clinical use.
SES2.1.2	**M**	The tester is independent of the manufacturer.	**M**	**Revised** The tester is independent of the manufacturer (e.g. biomedical engineer).
SES2.1.4			**M**	**New** Records of the safety tests are reviewed and approved by the medical director before clinical use. *Guidance: There is a record that the medical director has authorized equipment for diagnostic testing.*
SES2.1.5	**M**		**M**	**New** Safety testing records are available for review.
SES2.1.6	**M**		**M**	**New** DAP is notified of new or replaced equipment prior to clinical use. *Guidance: a notice of significant change in service from must be submitted to the DAP (https://www.cpsbc.ca/files/pdf/DAP-PS-Notification-Significant-Change.pdf).*

No.	Version 1.2	Version 2.0
SES2.1.7		**M** **New** The record of approval by the medical director that the equipment is ready for clinical use is submitted to the DAP (e.g. letter).
SES2.2		**M** **New** Validation testing is performed prior to clinical use of equipment.
SES2.2.1		**M** **New** Validation testing is performed after relocation and prior to clinical use. Guidance: Validation is conducted after equipment is relocated or repurposed and has recent safety testing performed.
SES2.2.2		**M** **New** Validation testing is conducted by a qualified person.
SES2.2.3		**M** **New** The assigned person for conducting validation testing has appropriate training and approved by the medical director.
SES2.2.4		**M** **New** A mock test is conducted on a "real" person. *Guidance: A minimum of one hour of data is collected*.
SES2.2.5		**M** **New** All parameters necessary for the diagnostic test are evaluated.
SES2.2.6		**M** **New** Validation records are reviewed and approved by the medical director before clinical use.
SES2.2.7		**M** **New** Safety testing records are available for review.
SES2.3		**M** **New** Equipment testing is regularly conducted to ensure accurate results.

No.	Version 1.2	Version 2.0
SES2.3.1		**M** **New** Preventative maintenance is conducted as per the manufactures' recommendation.
SES2.3.2		**M** **Relocated from SES1.3.12** Grounding and current leakage of all instruments connected directly to the patient are periodically tested. *Guidance: It is recommended that testing for grounding and current leakage of all the instruments be performed quarterly.*

Global polysomnography

No.	Version 1.2	Version 2.0
GS1.1.5		**M** **New** The medical director approves the list of qualified physicians that can directly refer to the polysomnography facility for testing.
GS1.1.6		**New** Standardized referral forms and practices developed by the Guideline and Protocol Advisory Committee (GPAC) are used. • Form A: Requisition for Home Sleep Apnea Testing • Form B: Referral Request – Sleep Disorder Consultation
GS1.1.7		**M** **New** The approved diagnostic outpatient requisition for HSAT is used. *Guidance: Form A: Requisition for Home Sleep Apnea Testing*
GS1.2.2	**M** Processes are in place to assess test appropriateness.	**M** **Revised** A documented process is in place to assess test appropriateness and highlight complex studies.

No.	Version 1.2	Version 2.0
GS1.2.3		**M** **New** The individual delegated to evaluating test requests is approved by the medical director and provided with appropriate training. *Guidance: The referral review process helps the facility to determine which patients are appropriate for testing and provide specific instructions to the technologist.*
GS1.2.4		**M** **New** Test requests that do not meet criteria are reviewed by the medical director or physician designate.
GS1.2.5		**M** **New** There is a process for all pediatric referrals to be triaged by a qualified sleep physician. *Guidance: The designated physician that reviews pediatric referrals has the appropriate credentials to review the age specific referrals.*
GS1.3.4	**M** Requests contain accurate and appropriate information that includes gender.	**Deleted**
GS1.4		**New** Consultations are comprehensive and include clinically relevant information.
GS1.4.1		**M** **New** A consultation is conducted prior to testing by a qualified physician.
GS1.4.2		**M** **New** Consultation notes are forwarded to the facility to review prior to testing.
GS1.4.3		**M** **New** There is a process to ensure that the patient and the referring physician are notified when a consultation is completed, and patient care is transferred back to the referring physician, or another care provider.

No.	Version 1.2	Version 2.0	
GS1.4.4		**M**	**New** Non-physicians conducting a preliminary history on a patient are appointed by the medical director. *Guidance: During the consultation process non-physicians may assist sleep specialists to obtain relevant medical information that will assist them in determining necessary medical interventions.*
GS1.4.5		**M**	**New** Non-physicians conducting a preliminary history have relevant credentials, training and defined parameters. *Guidance: Refer to the technical staff requirements and scoring section for additional guidance and criteria.*
GS1.4.6		**M**	**New** Prior to booking a patient test there is a record that a qualified physician reviews non-physician assistance documentation.
GS1.5			**New** Booking patients is done in a manner to ensure appropriate scheduling and staff resources.
GS1.5.1		**M**	**New** There is a process in place to assess test appropriateness and highlight complex studies.
GS1.5.2			**New** There is an attempt to ensure that the number of complicated sleep patients is limited to one per sleep technologist during the nocturnal study. *Guidance: Complex studies may require additional resources or therapist intervention and should be taken into account when booking sleep study schedules (e.g. ASV or AVAP/iVAPS titrations).*

No.	Version 1.2		Version 2.0
GS2.1.5			**New** Examination request guidelines, such as patient instructions, are available to patients and referring practitioners.
GS2.1.6			**New** Patients are provided information on how to access the service location, entry times and examination cancellation policy.
GS3.2.5		**M**	**New** Documentation defines pediatric age classifications and incorporates age specific criteria for testing (e.g. pediatrics). *Guidance: Refer to the polysomnography pediatric category accreditation standards for further guidance.*
GS3.4.5	All the information necessary to perform the test is available and includes normative values.		**Deleted**
GS4.1	Tests are labeled in a standardized way that allows for proper patient identification.		**Revised** Test data is labeled in a standardized way that allows for proper patient identification.
GS4.1.3	Tests are labelled in a standardized way that allows for proper patient identification that includes facility name.	**M**	**Revised** Testing data is labeled to include facility name and address.
GS4.1.4	Tests are labelled in a standardized way that allows for proper patient identification that includes date and time of test.	**M**	**Revised** Testing data is labeled to include date of test(s).
GS4.1.7	Tests are labelled in a standardized way that allows for proper patient identification that includes patient's gender.		**Deleted**

No.	Version 1.2		Version 2.0	
GS4.2.2		Comprehensive test details are recorded in the medical record that includes the technologist performing the test.	**M**	**Revised** Testing details are recorded in the medical record to include technologist performing test. *Guidance: There is a process to identify the individual performing the test (e.g. if a unique identification is used).*
GS4.2.3	**M**	Comprehensive test details are recorded in the medical record that includes date and time of test.	**M**	**Revised** Testing details are recorded in the medical record to include date of test(s).
GS5.1		Reports are comprehensive and include appropriate patient and relevant clinical information.		**Revised** Diagnostic reports are comprehensive and include appropriate patient and clinical information.
GS5.1.4	**M**	Diagnostic reports include the gender.		**Deleted**
GS5.1.5	**M**	Diagnostic reports include the facility name.		**Revised** Diagnostic reports include facility name and address.
GS5.1.6	**M**	Diagnostic reports include the test performed.	**M**	**Revised** Diagnostic reports include test(s) performed.
GS5.1.11			**M**	**Deleted** Diagnostic reports include the time of test, if relevant (e.g. patients likely to have more than one test type per day)
GS5.2.1		Standardized report templates are used.		**Revised** Standardized report templates for all diagnostic tests are used and approved by the medical director.
GS5.2.2	**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.*	**M**	**Revised** The final report package includes interpretation.

No.	Version 1.2		Version 2.0	
GS5.2.3	**M**	The body of the report includes the findings. *Guidance: The report uses appropriate anatomic, pathologic, and diagnostic terminology to describe the findings.*	**M**	**Revised** The final report package includes the technical summary sheet.
GS5.2.4	**M**	The body of the report includes potential limitations *Guidance: The report, when appropriate, identifies factors that may compromise the test. Any known significant patient reaction or complication is recorded.*	**M**	**Revised** The final report package includes the summary of the scored data. *Guidance: PSG results are documented in a brief comprehensive summary report that includes observations and analysis of recorded parameters.*
GS5.2.5	**M**	The body of the report includes clinical issues or concerns *Guidance: The report addresses or answers any specific clinical questions.*	**M**	**Revised** The content of the final report package is defined. *Intent: The final report may be unique to the service and consist of a combination of different testing details (e.g. interpretation, scored data, physician notes, cover letters, etc.).*
GS5.2.6	**M**	The body of the report includes the impression (e.g. conclusion or diagnosis).	**M**	**Revised** Documentation authored by non-medical staff do not make any recommendations, claims of diagnosis or requests for prescriptions.
GS5.2.7	**M**	The body of the report includes comparison with relevant tests and reports is included in the final report.	**M**	**Revised** All communication documentation is approved by the medical director (e.g. final report, education materials, cover letters, handouts, etc.).
GS5.3		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 communication of results are encouraged in certain situations.		**Revised** An accurate final report is issued for all tests. *Guidance: A final report is the definitive means of communicating test results to the authorized individual or other relevant health-care provider. Additional methods for communication of results are encouraged in certain situations.*

No.	Version 1.2	Version 2.0	
GS5.3.3	Verified reports are signed by the reporting physician.	**M**	**Revised** Verified reports are signed by the interpreting physician. *Guidance: Verified reports may be signed electronically or manually.*
GS5.3.8	The use of abbreviations or acronyms is limited to avoid ambiguity.		**Relocated to GS 5.1.11**
GS5.4			**New** Interpretations are comprehensive and include all necessary information for clinical decision-making.
GS5.4.1		**M**	**New** Standardized interpretation formats are used and approved by the medical director.
GS5.4.2		**M**	**New** The interpretation report includes the indication for testing.
GS5.4.3		**M**	**New** The interpretation report includes the test(s) performed.
GS5.4.4		**M**	**New** The interpretation report includes the clinical issues or concerns during the test.
GS5.4.4		**M**	**New** The interpretation report includes the statement about the quality of the test.
GS5.4.5		**M**	**New** The interpretation report includes the summary of the findings.
GS5.4.6		**M**	**New** The interpretation report includes the impression statement.

No.	Version 1.2	Version 2.0	
GS5.4.7		**M**	**New** The interpretation report includes the recommendations. *Guidance: Recommendations may be included in the interpretation, but also may include details from the post-sleep consultation notes.*
GS5.4.8		**M**	**New** Attestation statement from the interpreting physician that the scored data has been reviewed.
GS5.4.9		**M**	**New** Deficiencies in scored data or errors are evaluated by the interpreting physician. *Guidance: The interpreting physician may request raw data or send back to the scorer for clarification.*
GS5.4.10		**M**	**New** Interpreting physicians evaluates abnormal findings and recommendations are communicated back to the referring physician (e.g. risk of driving).
GS5.4.11		**M**	**New** The use of abbreviations or acronyms is limited to avoid ambiguity.
GS5.4.12			**New** Previous reports are available for review and comparison.

Governing body

No.	Version 1.8		Version 2.0
GOVB1.0			**New** **GOVERNING BODY RESPONSIBILITIES**
GOVB1.1			**New** **The governance structure of the service is defined.**
GOVB1.1.1		**B**	**New** The governing body defines the corporate governance structure. *Guidance: Corporate governance is the system of responsibilities, processes and structures by which the service is directed and controlled.*
GOVB1.1.2		**B**	**New** The governing body defines corporate governance roles and responsibilities.
GOVB1.1.3		**B**	**New** The governing body defines the clinical governance structure. *Guidance: Clinical governance is the framework through which medical director, governing body and staff are accountable for delivery of high quality and safe health care.*
GOVB1.1.4		**B**	**New** The governing body defines clinical governance roles and responsibilities.
GOVB1.2			**New** **The organizational structure of the service is defined.**
GOVB1.2.1		**M**	**New** There is an organization chart which delineates the lines of accountability, responsibility and authority of governing body, medical, technical and administrative staff.

No.	Version 1.8	Version 2.0
GOVB1.2.1		**M** **New** The organizational chart is dated.
GOVB1.3		**New** **The governing body appoints individual(s) to fulfill the corporate and clinical governance responsibilities.**
GOVB1.3.1		**M** **New** The governing body appoints a medical director. *Guidance: See MDIR1.0 for additional requirements.*
GOVB1.3.2		**M** **New** The governing body, in collaboration with the medical director or delegate, appoints medical leaders for specific sections/departments/programs within the service. *Guidance: Medical, administrative and technical leaders work collaboratively to provide effective quality and safety oversight of the service.*
GOVB1.3.3		**M** **New** The governing body, in collaboration with the medical director or delegate, appoints technical leaders for specific sections/departments/programs within the service. *Guidance: Medical, administrative and technical leaders work collaboratively to provide effective quality and safety oversight of the service.*
GOVB1.3.4		**B** **New** The governing body, in collaboration with the medical director or delegate, appoints administrative leaders for specific sections/departments/programs within the service. *Guidance: Medical, administrative and technical leaders work collaboratively to provide effective quality and safety oversight of the service.*

No.	Version 1.8	Version 2.0
GOVB1.3.5		**B** **New** The governing body, in collaboration with the medical director or delegate, appoints medical staff. *Guidance: See Medical Staff Qualification and Requirements.*
GOVB1.3.6		**B** **New** Specific staff are assigned accountability and responsibility for safety.
GOVB1.3.7		**B** **New** Specific staff are assigned accountability and responsibility for financial management/planning.
GOVB1.3.8		**B** **New** Specific staff are assigned accountability and responsibility for human resources.
GOVB1.3.9		**B** **New** Specific staff are assigned accountability and responsibility for infection prevention and control.
GOVB1.3.10		**B** **New** Specific staff are assigned accountability and responsibility for risk management.
GOVB1.3.11		**B** **New** Specific staff are assigned accountability and responsibility for information management.
GOVB1.3.12		**B** **New** Specific staff are assigned accountability and responsibility for education and training.
GOVB1.3.13		**B** **New** Specific staff are assigned accountability and responsibility for complaint management.
GOVB1.3.14		**B** **New** Specific staff are assigned accountability and responsibility for disaster planning.

No.	Version 1.8	Version 2.0
GOVB1.3.15		**B** **New** Specific staff are assigned accountability and responsibility for quality improvement.
GOVB1.3.16		**B** **New** Specific staff are assigned accountability and responsibility for indigenous cultural safety and humility (e.g. Indigenous patient navigators).
GOVB1.3.17		**B** **New** Specific staff are assigned accountability and responsibility for policy development.
GOVB1.3.18		**B** **New** Specific staff are assigned accountability and responsibility for equipment and supplies management.
GOVB1.3.19		**B** **New** Specific staff are assigned accountability and responsibility for data security.
GOVB1.3.20		**B** **New** Specific staff are assigned accountability and responsibility for technical operations.
GOVB1.4		**New** **The governing body defines and communicates the mission and values.**
GOVB1.4.1		**B** **New** The mission and values are defined.
GOVB1.4.2		**B** **New** The mission and values are communicated to all staff.
GOVB1.5		**New** **The governing body defines the strategic and operational objectives.**

No.	Version 1.8	Version 2.0
GOVB1.5.1		**B** **New** The strategic plan is documented. *Guidance: The strategic plan sets the priorities and direction of the service.*
GOVB1.5.2		**B** **New** The operational plan is documented. *Guidance: The operational plan guides the service in achieving its strategic goals and objectives. The medical, administrative and technical leaders of the service establish an operational plan that is aligned with the strategic direction of the organization and includes defined monitoring and measurement of the plan's progress.*
GOVB1.5.3		**B** **New** The financial plan is documented. *Guidance: The financial plan includes the projecting, monitoring, organizing and controlling of the monetary resources of the service. The resources required to deliver the scope of service are identified. The financial plan is developed with input from key leaders.*
GOVB1.6		**New** **The governing body defines the ethics.**
GOVB1.6.1		**B** **New** The ethics or code of behavior are documented. *Guidance: The governing body/ownership is responsible for defining the ethics or code of behavior of the organization. Ethics outlines the culture, attitudes, beliefs and behaviors that govern the service's conduct such as openness, integrity and trust.*
GOVB1.6.2		**B** **New** The process for addressing unethical, unprofessional and or illegal behavior in a defined time frame is documented.

No.	Version 1.8	Version 2.0
GOVB1.6.3		**B** **New** The process to receive and resolve ethical dilemmas in a in a defined time frame is documented. *Guidance: Ethical dilemmas may include decisions not to perform an examination or where an examination is performed against the wishes of the patient.*
GOVB1.7		**New** **The governing body safeguards impartiality and conflict of interest.**
GOVB1.7.1		**B** **New** The governing body is structured and managed to safeguard impartiality and conflicts of interest. *Guidance: See CPSBC practice standard for advertising and communication with the public, available from https://www.cpsbc.ca/files/pdf/PSG-Advertising.pdf .* *See CPSBC practice standard for conflict of interest, available from https://www.cpsbc.ca/files/pdf/PSG-Conflict-of-Interest.pdf*
GOVB1.7.2		**B** **New** For private payment services, patients are provided information regarding what conditions, if any, the service would be eligible for Medical Service Plan, MSP, coverage.
GOVB1.8		**New** **The governing body identifies and manages risk.**
GOVB1.8.1		**B** **New** The risk management framework is documented. *Guidance: A risk management framework is used to identify and manage significant clinical and non-clinical. Risk management frameworks are service or modality specific, where applicable*
GOVB1.8.2		**B** **New** The risk management framework includes the scope, objectives and criteria for assessing risk.

No.	Version 1.8	Version 2.0
GOVB1.8.3		**B** **New** The risk management framework includes identification of risk management responsibilities and functions.
GOVB1.8.4		**B** **New** The risk management framework includes a training program for staff involved in risk assessment activities.
GOVB1.8.5		**B** **New** The risk management framework includes risk plans to address significant risks to the organization.
GOVB1.8.6		**B** **New** The risk management framework includes policies and procedures for reporting, resolving, reviewing, monitoring and communicating risks. *Guidance: Risk are communicated to applicable staff and community interests (e.g. firehall).*
GOVB1.8.7		**M** **New** A risk assessment of clinical processes and procedures is performed to safeguard patients from unintended consequences of care. *Intent: At a minimum, the service reviews the examinations performed and identifies those that have a high risk to cause harm.*
GOVB1.8.8		**B** **New** The risk management framework includes processes on how reactive risks are addressed.
GOVB1.8.9		**B** **New** A risk register with associated risk levels is documented. *Guidance: The risk register is a list of identified strategic, operational, financial and clinical risks and their assessed risk level.*

No.	Version 1.8	Version 2.0
GOVB1.8.10		**M** **New** High-risk processes and procedures are reviewed on a regular basis to make improvements and reduce risk, when possible. *Guidance: The review of high-risk processes and procedures should include analyzing incident and adverse event reports, reviewing policies and procedures associated with the processes to minimize risk, and assessing the effectiveness of measures implemented to mitigate risk.*
GOVB1.9		**New** **The governing body defines and communicates the scope of services.**
GOVB1.9.1		**B** **New** The governing body determines the scope of services using a process that considers relevant factors (e.g. patient population, existing capacity, clinical value of testing, etc.).
GOVB1.9.2		**B** **New** The scope of service is documented and communicated to all staff.
GOVB1.9.3		**B** **New** The scope of service is communicated to referring physicians.
GOVB1.9.4		**B** **New** The scope of service is communicated to the public. *Guidance: This information may be on the facility or organization's website or on the requisition.*

No.	Version 1.8	Version 2.0
GOVB1.9.5		**M** **New** The DAP accreditation certificate is posted in a public area. *Guidance: The DAP accreditation certificate is posted to notify patients the scope of services which are accredited by the College of Physicians and Surgeons of BC.*

Medical director

No.	Version 1.8	Version 2.0
MDIR1.0		**New** **MEDICAL DIRECTOR QUALIFICATIONS**
MDIR1.1		**New** **The physician appointed as medical director is qualified to fulfill their clinical governance responsibilities.**
MDIR1.1.1		**M** **New** The medical director is a licensee of the College of Physicians and Surgeons of BC.
MDIR1.1.2		**M** **New** The medical director has credentials, as approved by the DAP committee. *Intent: Credentials may include, but are not limited to, skills, education, experience, registration class, speciality and practice conditions.*
MDIR1.1.3		**M** **New** The medical director must reside in British Columbia.
MDIR2.0		**New** **MEDICAL DIRECTOR RESPONSIBILITIES**
MDIR2.1		**New** **Medical director is accountable and responsible for the service.**

No.	Version 1.8	Version 2.0
MDIR2.1.1		**M** **New** The medical director is accountable and responsible for ensuring the service's compliance with DAP standards, DAP policies, DAP accreditation agreements, CPSBC Bylaws, CPSBC standards of practice.
MDIR2.1.2		**M** **New** The medical director is accountable and responsible for the clinical operations of the service.
MDIR2.1.3		**M** **New** The clinical governance duties and responsibilities of the medical director are defined and documented.
MDIR2.1.4		**B** **New** The medical director is accountable and responsible for demonstrating and promoting a patient safety culture.
MDIR2.1.5		**B** **New** The medical director is accountable and responsible for assessing and managing clinical risk through the organization's risk management framework.
MDIR2.1.6		**B** **New** The medical director is accountable and responsible for the review, investigation and reporting, as required, of patient safety incidents and near misses.
MDIR2.1.7		**B** **New** The medical director is accountable and responsible for the review, investigation and resolution of all complaints regarding the quality and safety of patient care delivery.
MDIR2.1.8		**B** **New** The medical director is accountable and responsible for evaluating, monitoring and continually improving the facility's quality of services.

No.	Version 1.8		Version 2.0
MDIR2.2			**New** **The medical director is accountable and responsible for the clinical oversight of medical staff.**
MDIR2.2.1		**M**	**New** The medical director is accountable and responsible for continuously monitoring the professional performance of medical staff through a medical peer review process. *Guidance: See the quality improvement standards for additional guidance regarding medical peer review programs.*
MDIR2.2.2		**M**	**New** The medical director is accountable and responsible for ensuring that medical leaders have the qualifications and skills necessary to provide supervision to their assigned area(s) of responsibility. *Guidance: The medical director works in collaborate with the governing body to appoint medical leaders.*
MDIR2.3			**New** **The medical director is accountable and responsible for clinical oversight of the service.**
MDIR2.3.1		**M**	**New** The medical director is accountable and responsible for authorizing and implementing standardized reporting templates.
MDIR2.3.2		**B**	**New** The medical director is accountable and responsible for authorizing and implementing standardized interpretive comments.
MDIR2.3.4		**M**	**New** The medical director is accountable and responsible for authorizing and implementing technical/medical/clinical policies, protocols and procedures related to the service.

No.	Version 1.8	Version 2.0
MDIR2.3.5		**M** **New** The medical director is accountable and responsible for continuously monitoring the performance of the service and technical staff through quality improvement activities.
MDIR2.3.6		**M** **New** The medical director is accountable and responsible for authorizing the scope of services, emergency response plans, and service consultation processes for 'remote/rural' facilities, which are facilities with limited onsite oversight by the medical director, medical leaders and or technical leaders. *Guidance: An example of a 'remote/rural facility' may be a community level satellite service centre associated with hospital, which has no onsite emergency services and no regular onsite technical or medical leadership.*
MDIR2.4		**New** **The medical director conducts safety and quality audits.**
MDIR2.4.1		**M** **New** Prior to assuming medical director responsibilities of a new service, the medical director conducts an on-site safety and quality audit of the service.
MDIR2.4.2		**M** **New** Prior to assuming medical director responsibilities of an existing service, the medical director or delegate conducts an on-site safety and quality audit of the service.

No.	Version 1.8	Version 2.0
MDIR2.4.3		**M** **New** The medical director defines the criteria and scope of safety and quality auditing. *Guidance: A safety and quality audit may include, but is not limited to, a general assessment of the service's compliance to organization's policies, procedures, patient care guidelines, DAP standards and an evaluation of patient care delivery across all stages (pre-admission, admission, examination/procedure, recovery, interpretation, results discharge, etc.).*
MDIR2.4.4		**M** **New** The medical director defines the method of routine safety and quality auditing (e.g. on-site or virtual). *Guidance: The DAP recommends that the medical director or delegate be physically present at the facility to conduct the audit. The medical director may authorize, reflective of risks associated with the service, that the audit be performed through virtual means (e.g. video review of the facility).*
MDIR2.4.5		**M** **New** The medical director defines the frequency of safety and quality auditing. *Guidance: The frequency of audits reflects the relevant risk associated with the service.*
MDIR2.4.6		**M** **New** Routinely the medical director or delegate conducts safety and quality audits of the service.
MDIR2.4.7		**M** **New** If the medical director does not regularly attend the facility (e.g. rural hospital) a safety and quality audit of the service is conducted annually.

No.	Version 1.8	Version 2.0
MDIR2.4.8		**M** **New** If a service medical leader(s) and or technical leader(s) does not regularly attend the facility (e.g. remote community facility) a safety and quality audit of the service is conducted semi-annually.
MDIR2.4.9		**M** **New** The medical director meets with the governing body, leadership teams and staff, as applicable, to review the audit and continually improve the service's safety and quality of care. *Guidance: If a delegate conducts the safety and quality audit, the results are reviewed by the medical director.*
MDIR2.5		**New** **The medical director notifies the DAP of any significant events.**
MDIR2.5.1		**M** **New** The medical director notifies the DAP of any significant events, which includes: • Change to the physical location of services • Installation/relocation of new or significantly retrofitted equipment • Change in medical directorship • Change in interpreting physicians and/or location of interpreting physicians • Change in the scope of services *Intent: A notification of intendent significant event form must be submitted to the DAP. A change in medical directorship describes when a new medical director is appointed. If the active medical director is on vacation, they must appoint a delegate, but notification to the DAP is not required.*

Medical staff qualifications and requirements

No.	Version 1.8		Version 2.0
MSQR1.0			**New** **MEDICAL STAFF QUALIFICATIONS AND REQUIREMENTS**
MSQR1.1			**New** **Medical staff are qualified and competent.**
MSQR1.1.1		**M**	**New** Medical staff have relevant education and training.
MSQR1.1.2		**M**	**New** Medical staff have the physical ability to perform the scope of practice/procedure.
MSQR1.1.3		**M**	**New** Medical staff have the experience and competency to perform the scope of practice/procedure.
MSQR1.2			**New** **The service maintains a list of medical staff.**
MSQR1.2.1		**M**	**New** A list of practicing medical staff is maintained.
MSQR1.2.2		**M**	**New** The authorized scope of service/procedures all medical staff is documented and communicated.
MSQR2.0			**New** **CREDENTIALING AND PRIVILEGING** *Guidance: 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.*

No.	Version 1.8		Version 2.0
MSQR2.1			**New** **There is a process of medical staff credentialing and privileging.**
MSQR2.1.1		**M**	**New** There is a process for credentialing and privileging medical staff. *Guidance: There is a formal process used for credentialing and privileging. Medical staff must have the requisite credentials as outlined in the B.C. Provincial Privileging Dictionaries, available from, http://bcmqi.ca/privileging-dictionaries. For more information regarding credentialing and privileging facilities may wish to reference the DAP credentialling website, available from: https://www.cpsbc.ca/accredited-facilities/dap/credentialing.*
MSQR2.1.2		**M**	**New** The governing body, in collaboration with the medical director, grants medical staff privileges.
MSQR2.1.3		**M**	**New** The governing body, in collaboration with the medical director, ensures medical staff are qualified and practise only within their scope and competence.
MSQR2.2			**New** **Medical staff have the requisite credentials for privileges as outlined in the BC Provincial Privileging Dictionaries**

No.	Version 1.8	Version 2.0
MSQR2.1.4		**M** **New** Medical staff have the requisite credentials for privileges as outlined in the B.C. Provincial Privileging Dictionaries, associated with the scope of services/procedures they perform. *Guidance: Services/procedures are considered core and non-core privileges depending on the relevant specialty and therefore may require further training, experience and demonstrated skill. Refer to http://bcmqi.ca/privileging-dictionaries/ for the requirements to perform services. Licensee and Non-Licensee must meet the B.C. Provincial Privileging Dictionaries.*

Delegated medical acts

No.	Version 1.8	Version 2.0
DMA1.0		**New** **DELEGATED MEDICAL ACTS**
DMA1.1		**New** **The delegation of medical acts has been approved and accepted.**
DMA1.1.1		**M** **New** The medical director may delegate selected duties and responsibilities to qualified and competent staff.
DMA1.1.2		**M** **New** The medical director authorizes the policies and procedures for the delegation of medical acts.
DMA1.1.3		**M** **New** Approval from the medical director and governing body has been obtained prior to the delegated medical act being carried out.

No.	Version 1.8	Version 2.0
DMA1.1.4		**M** **New** The delegation of the medical act has been accepted by the individual(s) who will perform the delegated medical act.
DMA1.1.5		**M** **New** The service maintains a list of approved medical acts and the individuals authorized to conduct each delegated medical act.
DMA1.2		**New** **Delegated medical acts are clearly defined.**
DMA1.2.1		**M** **New** Delegated medical act duties and responsibilities are documented.
DMA1.2.2		**M** **New** Delegated medical act procedures and protocols are documented.
DMA1.2.3		**M** **New** The method of medical supervision for delegated medical acts is documented. *Guidance: Medical supervision may be direct, with the physician in attendance, or through technology (video link, digital imaging, telephone), or according to a written protocol.*
DMA1.3		**New** **Delegated medical acts are performed by qualified and competent.**
DMA1.3.1		**M** **New** The competency requirements to perform delegated medical acts are documented.
DMA1.3.2		**M** **New** Additional training is provided to individuals performing delegated medical acts.

No.	Version 1.8	Version 2.0
DMA1.3.3		**M** **New** An initial competency assessment of the individual performing the delegated medical act is conducted by a physician or technical delegate, prior to the individual being authorized to perform the delegated medical act. *Guidance: Competency assessment of the technical delegate is conducted by a physician with relevant expertise in the medical act.*
DMA1.3.4		**M** **New** A routine competency assessment of the individual performing the delegated medical act is conducted by a physician or technical delegate, at defined intervals, as per the medical director. *Guidance: The record of assessment for each individual is updated following the reassessment.*
DMA1.4		**New** **Delegated medical act competency assessment records.**
DMA1.4.1		**M** **New** Competency assessment records are maintained for all individuals authorized to perform delegated medical acts.
DMA1.4.2		**M** **New** Delegated medical act competency assessment records include the date of the assessment.
DMA1.4.3		**M** **New** Delegated medical act competency assessment records include the specific act(s) being assessed.
DMA1.4.4		**M** **New** Delegated medical act competency assessment records include the specific act(s) being assessed the name of the physician or technical delegate conducting the assessment.

No.	Version 1.8	Version 2.0
DMA1.4.5		**M** **New** Delegated medical act competency assessment records includes the signature of the individual attesting to the competence of the individual performing the specific act(s).

Staff administration, management and development

No.	Version 1.8	Version 2.0
STAFF1.0		**New** **STAFF ADMINISTRATION, MANAGEMENT AND DEVELOPMENT**
STAFF1.1		**New** **The human resources plan is defined.**
STAFF1.1.1		**B** **New** The governing body, medical director and applicable leaders participate in the development of the human resources plan.
STAFF1.1.2		**M** **New** The human resources plan identifies the requirements for adequate staffing levels, which meets the current and futures needs of the service. *Guidance: The medical director makes recommendation on the number of qualified competent medical staff necessary to ensure quality and safety of diagnostic service provision.*
STAFF1.1.3		**M** **New** The human resources plan identifies the requirements for staff credentials and qualifications, which meets the current and futures needs of the service.
STAFF1.1.4		**M** **New** The human resources plan identifies the requirements for staff training.

No.	Version 1.8	Version 2.0
STAFF1.1.5		**M** **New** The human resources plan identifies when criminal records checks are performed.
STAFF1.1.6		**B** **New** The human resources plan identifies any vaccinations or immunization requirements for staff, in accordance with facility policy and applicable legislation and public health orders.
STAFF1.1.6		**B** **New** The human resources plan is monitored and revised as required.
STAFF1.2		**New** **Human resources and employment practices align with the mission and values of the service.**
STAFF1.2.1		**B** **New** Human resource and employment practices foster diversity, equity and inclusion. *Guidance: Human resource practices reflect applicable provincial employment codes and standards such as the B.C. Human Rights Code which protects people from discrimination in hiring or on the job if the discrimination is based on one or more of the protected personal characteristics.*
STAFF1.2.2		**B** **New** Human resource and employment practices promote health and safety.
STAFF1.2.3		**B** **New** Human resource and employment practices promote staff well-being.
STAFF1.3		**New** **Job descriptions are defined and communicated.**

No.	Version 1.8	Version 2.0
STAFF1.3.1		**M** **New** There are job descriptions for all staff that reflect current practice and evolving responsibilities.
STAFF1.3.2		**B** **New** Job descriptions are reviewed and revised as required.
STAFF1.4		**New** **There is a process to recruit and retain qualified staff.**
STAFF1.4.1		**M** **New** Staff are selected based on qualifications and experience (e.g. certification, academic preparation, knowledge, skills, and reference checks).
STAFF1.4.2		**B** **New** There are strategies in place to retain staff (e.g. contributions by staff are recognized).
STAFF1.4.3		**B** **New** There are mechanisms in place to assess and enhance staff engagement, motivation and morale (e.g. involvement in appropriate decision-making, staff surveys).
STAFF1.4.4		**B** **New** There are processes for staff to bring forward concerns/complaints, and for the diagnostic service leadership to respond in a fair, objective and timely manner.
STAFF1.4.4		**B** **New** Schedule/workload reviews are performed to assess and maintain acceptable allocated examination times for routine and complex examinations.
STAFF1.5		**New** **Human resources records are retained for all staff.**

No.	Version 1.8	Version 2.0
STAFF1.5.1		**M** **New** Staff records include evidence of qualification and credentials (e.g. certification or registration documents).
STAFF1.5.2		**M** **New** Staff records include criminal record checks, as required.
STAFF1.5.3		**M** **New** Staff records include competency assessments.
STAFF1.5.4		**B** **New** Staff records include orientation, continuing education and training records.
STAFF1.6		**New** **Human resource records are maintained in a confidential manner.**
STAFF1.6.1		**M** **New** Only authorized individuals have access to records.
STAFF1.6.2		**M** **New** Consent is obtained prior to the release of information contained in human resource record. *Intent: Consent from the employee is required for the release of human resource records outside of the organization. Internal access to records (e.g. interdepartmental release) is limited to authorized individuals within the organization.*
STAFF1.6.3		**B** **New** There is a process for the maintenance and disposal of human resource records, in accordance with applicable legislation.
STAFF1.7		**New** **Orientation is provided to all staff.**

No.	Version 1.8	Version 2.0
STAFF1.7.1		**M** **New** Staff orientation includes the responsibilities, policies and procedures specific to their role.
STAFF1.7.2		**M** **New** Staff orientation includes equipment use (e.g. primary and ancillary).
STAFF1.7.3		**M** **New** Staff orientation includes equipment quality assurance.
STAFF1.7.4		**M** **New** Staff orientation includes safety (i.e. occupational and patient).
STAFF1.7.5		**M** **New** Staff orientation includes patient identification.
STAFF1.7.6		**M** **New** Staff orientation includes confidentiality.
STAFF1.7.7		**B** **New** Staff orientation includes data security.
STAFF1.7.8		**M** **New** Staff orientation includes consent and patient rights.
STAFF1.7.9		**M** **New** Staff orientation includes information management.
STAFF1.7.10		**M** **New** Staff orientation includes infection prevention and control.
STAFF1.7.11		**M** **New** Staff orientation includes WHMIS and other local, provincial and federal requirements.
STAFF1.7.12		**M** **New** Staff orientation includes ergonomics and prevention of work-related muscular disorders.

No.	Version 1.8	Version 2.0
STAFF1.7.13		**M** **New** Staff orientation includes management and reporting of adverse events and critical incidents.
STAFF1.7.14		**M** **New** Staff orientation includes management and reporting of violence, aggressive behavior and harassment.
STAFF1.7.15		**M** **New** Staff orientation includes emergency response/codes.
STAFF1.7.16		**M** **New** Staff orientation includes fire response.
STAFF1.7.17		**M** **New** Staff orientation includes disaster response.
STAFF1.7.18		**B** **New** Staff orientation includes sharps handling and disposal, as applicable to job role.
STAFF1.7.19		**B** **New** Staff orientation includes the mission and values.
STAFF1.7.20		**B** **New** Staff orientation includes the ethics.
STAFF1.7.21		**B** **New** Staff orientation includes impartiality and conflict of interest.
STAFF1.7.22		**B** **New** Staff orientation includes the risk management framework.
STAFF1.7.23		**B** **New** Staff orientation includes the quality improvement program.
STAFF1.7.24		**B** **New** Staff orientation includes cultural and spiritual identities.

No.	Version 1.8	Version 2.0
STAFF1.7.25		**B** **New** Staff orientation includes gender expression and sexual orientation.
STAFF1.7.26		**B** **New** Staff orientation includes the complaints management process.
STAFF1.7.27		**B** **New** Staff orientation includes indigenous cultural safety, cultural humility and anti-racism.
STAFF1.7.28		**B** **New** Staff orientation includes complaint management.
STAFF1.7.29		**B** **New** Staff orientation includes patient centered care.
STAFF1.7.29		**M** **New** Orientation is provided to existing staff in response changes in roles, technology, competency demands, and regulations or after an extended absence.
STAFF1.8		**New** **Ongoing education and training is provided to all staff.**
STAFF1.8.1		**B** **New** The frequency of ongoing education and training is defined.
STAFF1.8.2		**M** **New** Ongoing education and training includes equipment use (e.g. primary and ancillary)
STAFF1.8.3		**M** **New** Ongoing education and training includes equipment quality assurance.
STAFF1.8.4		**M** **New** Ongoing education and training includes safety.

No.	Version 1.8	Version 2.0
STAFF1.8.5		**M** **New** Ongoing education and training includes patient identification.
STAFF1.8.6		**M** **New** Ongoing education and training includes confidentiality.
STAFF1.8.7		**B** **New** Ongoing education and training includes data security.
STAFF1.8.8		**M** **New** Ongoing education and training includes information management.
STAFF1.8.9		**M** **New** Ongoing education and training includes infection prevention and control.
STAFF1.8.10		**M** **New** Ongoing education and training includes management and reporting of adverse events and critical incidents.
STAFF1.8.11		**B** **New** Ongoing education and training includes risk management.
STAFF1.8.12		**B** **New** Ongoing education and training includes quality improvement.
STAFF1.9		**New** **The competency of staff is assessed.** *Intent: Competency assessments evaluate the knowledge, skills and abilities of staff to ensure that they are proficient in performing their duties.*
STAFF1.9.1		**M** **New** The competency assessment requirements for staff are defined

No.	Version 1.8	Version 2.0
		M **New** The frequency of routine competency assessments is defined.
STAFF1.9.2		
STAFF1.9.3		**B** **New** Individuals qualified to conduct competency assessments are identified.
STAFF1.9.4		**B** **New** The competencies for each assessment are defined (e.g. skills, procedures).
STAFF1.9.5		**B** **New** There is a record for each competency assessment.
STAFF1.9.6		**M** **New** Competency assessment of new staff is performed prior to the completion of a probationary or orientation period.
STAFF1.9.7		**M** **New** Competency assessment of existing staff is performed when new technology or new procedures are introduced.
STAFF1.9.8		**M** **New** Action is taken when a staff member's assessed competence does not meet expectations or when the staff member is not performing satisfactorily.
STAFF1.10		**New** **Staff receive performance appraisals.**
STAFF1.10.1		**B** **New** Development plans are generated, monitored and revised, as necessary.
STAFF1.11		**New** **Staff receive professional development and continuing education resources.**

No.	Version 1.8	Version 2.0
STAFF1.11.1		**B** **New** Staff are provided with professional development and continuing education resources.

Document control

No.	Version 1.8	Version 2.0
DOC1.0		**New** **THE SERVICE DEFINES AND MAINTAINS PROCEDURES TO CONTROL DOCUMENTS.** *Guidance: In this context, "document" can be policy statements, procedures and related job aids, instructions for use, protocols, procedures, manuals, standard operating procedures, etc. Documents can be in any form or type of medium, such as hard copy or digital.*
DOC1.1		**New** **The service defines and maintains document control procedures.**
DOC1.1.1		**M** **New** Documents (internal and external) which are related to the provision of service are controlled. *Guidance: In this context, "document" can be policy statements, procedures and related job aids, instructions for use, protocols, procedures, manuals, standard operating procedures, etc. Documents can be in any form or type of medium, such as hard copy or digital.*
DOC1.1.2		**M** **New** Documents include a unique identification.
DOC1.1.3		**M** **New** Documents include a current revision date or version.

No.	Version 1.8	Version 2.0
DOC1.1.4		**M** **New** Documents are approved for adequacy before issue by authorized personnel who have the expertise and competence to determine adequacy.
DOC1.1.5		**M** **New** Documents are periodically reviewed and updated as necessary.
DOC1.1.6		**M** **New** Relevant versions of applicable documents are available at points of use and, where necessary, their distribution is controlled.
DOC1.1.7		**M** **New** Documents are protected from unauthorized changes and any deletion or removal.
DOC1.1.8		**M** **New** Documents are protected from unauthorized access.
DOC1.1.9		**M** **New** Unintended use of obsolete documents is prevented, and suitable identification is applied to them if they are retained for any purpose.
DOC1.1.10		**M** **New** Handwritten amendments to documents indicate an entry date and the identification of the individual.
DOC1.1.11		**M** **New** Handwritten amendments to documents do not exceed 6 months since entry date. *Guidance: Documents are re-issued to include the amendments, as authorized.*
DOC1.2		**New** **There are mechanisms to communicate changes to documents.**

No.	Version 1.8	Version 2.0
DOC1.2.1		**M** **New** New or revised documents are communicated to staff. *Guidance: In this context, "document" can be policy statements, procedures and related job aids, instructions for use, protocols, procedures, manuals, standard operating procedures, etc. Documents can be in any form or type of medium, such as hard copy or digital.*
DOC1.2.2		**M** **New** The communication of documents is recorded.