COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

Diagnostic Accreditation Program

ACCREDITATION STANDARDS FOR INITIAL ASSESSMENT

Polysomnography

Diagnostic Accreditation Program
College of Physicians and Surgeons of British Columbia
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How to use this document

A new facility, new services provided by an accredited facility, or services that have implemented significant change **must** proceed through the initial assessment process and receive a provisional accreditation award **prior** to service delivery and testing of equipment on people.

The initial assessment process includes:

- the facility/service completing and submitting documentation that outlines the service profile, equipment, key individuals and their related qualifications, and other information as requested
- a DAP accreditation officer reviewing the submitted documentation and conducting an on-site visit of the facility/service

During the initial assessment process, the facility/service is assessed to a partial selection of the Diagnostic Accreditation Program (DAP) Accreditation Standards. This document, Accreditation Standards for Initial Assessment, identifies those standards that will be utilized by the DAP accreditation officer for conducting the initial assessment. A facility preparing for an initial assessment is strongly encouraged to review this document in their preparation, and to ensure all mandatory requirements have been fulfilled prior to contacting the DAP to schedule the on-site initial assessment. It is also suggested that the facility/service reviews the complete, comprehensive set of DAP Accreditation Standards as these documents provide additional guidance and explanations that the facility may find useful.

Evidence of compliance with mandatory requirements is required for the facility to be eligible to receive a provisional accreditation award. Mandatory requirements are identified by a bold type **M**.

Example

SSA1.0	POTENTIAL HAZARDS AND RISKS TO STAFF, PATIENTS AND VISITORS ARE MINIMIZED.	
SSA1.3	**Safety issues are discussed and monitored.**	
SSA1.3.1	**M**	The diagnostic service has a safety committee or health and safety representative. *Guidance: If there are 20 or more employees, a joint occupational health and safety committee (JOHSC) must be functioning. If the diagnostic service is part of a larger facility, a member of the committee must have the responsibility to represent the diagnostic service. If the facility has between 10 and 19 staff, the workers must select a person to be their Health and Safety Representative. This person, in effect, carries out the same functions as the committee in a larger facility. For organizations with less than 10 employees, the employer is required to hold regular meetings with the staff to discuss matters relating to maintaining a healthy and safe workplace. Records of these meetings must be kept. Sections 125 to 140 of the Workers Compensation Act provide all the details about committee requirements and function.*

Accreditation award

All mandatory requirements must be fully implemented for a facility to be eligible for a provisional accreditation award.

A new facility/service that is granted provisional accreditation status is permitted to commence service delivery to patients subject to satisfactory performance in fulfilling continuous accreditation requirements. If a facility/service is not awarded provisional accreditation, they are not permitted to commence service delivery.

Facilities are encouraged to contact an accreditation specialist at the DAP for more information on proceeding through the initial assessment process, and to arrange for an accreditation officer to conduct an initial assessment.

Quality category codes

Governance and leadership	SGL	Global polysomnography	GS
Medical staff	SMS	Polysomnography	PSG
Human resources	SHR		
Patient and client focus	SPC		
General safety	SSA		
Patient safety	SPS		
Infection prevention and control	SIPC		
Quality improvement	SQI		
Information management	SIM		
Equipment and supplies	SES		

Governance and leadership

Introduction

Each organization has a corporate governance structure that is ultimately responsible for the quality and safety of services provided. For large organizations, such as health authorities and some privately owned facilities, this governance structure is the board of directors. For other privately owned facilities the governance structure may be a partnership group or an individual as the sole proprietor. The term "governing body/ownership" is used in these standards to refer to those individuals who provide corporate governance to the organization.

Each organization, regardless of its complexity, also has a leadership structure. Many leadership responsibilities directly affect the provision of diagnostic services as well as the day to day operations of the diagnostic department. In some cases, these responsibilities will be shared amongst leaders; in other cases, a particular leader may have primary responsibility. Regardless of the organization's structure, it is important that leaders carry out all of their responsibilities.

Leadership

No.	Description
SGL2.0	**THE ACCOUNTABILITY AND RESPONSIBILITY FOR KEY LEADERSHIP FUNCTIONS IS ASSIGNED.** *Guidance: Functions may be assigned to an individual, leadership group or committee. An individual may be assigned to more than one key function.*
SGL2.2	**Responsibility for the clinical oversight of diagnostic service quality and safety is assigned and supported by the organization.** *Guidance: Clinical oversight describes a system through which an organization continually improves the quality of their services and safeguards high standards of care through an environment that promotes clinical excellence.*
SGL2.2.1	**M** A senior medical leader is appointed with responsibility for the quality and safety of the medical practice within the diagnostic service.
SGL2.2.2	**M** Medical leaders are actively involved in the monitoring of the clinical caseload.
SGL2.2.3	**M** Administrative and technical leaders are appointed with responsibility for the quality and safety of operational processes and technical operations within the diagnostic service. *Intent: It is the expectation that the job descriptions of diagnostic service leaders include quality and safety responsibilities.*
SGL2.3	**There is a documented and dated organizational chart.** *Guidance: The organizational chart includes medical, technical and administrative staff.*
SGL2.3.1	**M** The management structure of the diagnostic service is clearly delineated.
SGL2.3.2	**M** Lines of accountability, responsibility and authority, as well as the interrelationships of all staff are clear.
SGL2.3.3	**M** Relationships to other organizations are identified (e.g. remotely located medical leadership).

Medical staff

Introduction

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 governing body/ownership of the organization. The governing body/ownership 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 governing body/ownership.

Medical staff leadership

Introduction

For health authority/hospital based diagnostic services, the medical leader may have the title of chief, department head, medical director, or an alternate title. The medical leader and medical staff of health authority/hospital based diagnostic services operate within the provisions set out in the medical staff bylaws, and are accountable to the governing body through the established medical staff structure of the health authority/hospital.

In private diagnostic service facilities, each physician is responsible for ensuring the activities of medical leadership take place, including assuring the competence of all physicians providing medical services within the organization through a peer review process.

If a physician is the owner in solo practice, they are responsible for ensuring the activities of medical leadership take place, inclusive of ensuring that they are qualified and competent themselves to undertake the scope of medical service provided within their organization.

See also Quality Improvement Accreditation Standards SQI 4.1 – SQI 4.2.

No.		Description
SMS1.0		**A MEDICAL LEADER IS APPOINTED WITH ASSIGNED RESPONSIBILITIES AND ACCOUNTABILITIES FOR THE DIAGNOSTIC SERVICE.**
SMS1.1		**The medical leader has responsibility for medically related activities.**
		The medical leader:
SMS1.1.5	**M**	• establishes and monitors policies and procedures for the delegation of medical acts

No.	Description	
SMS1.1.6	**M**	• authorizes the implementation of technical/medical operational policies and procedures related to the diagnostic service

Remotely supervised facilities

Intent: Remotely supervised facilities provide services without medical leadership regularly on site. These facilities are typically small and located in remote communities where test interpretation is performed off-site at a larger facility or hospital.

No.	Description	
SMS1.2	**Medical leaders must visit the remotely supervised facility to assess the quality and safety of the service.**	
SMS1.2.1	**M**	The medical leader visits the facility prior to assuming responsibility for medical leadership for a new service.
SMS1.3	**Logs to record the medical leader or delegate visits to remotely supervised facilities are maintained.**	
SMS1.3.1	**M**	A log is kept to record the visit of the medical leader or delegate to the diagnostic service.
SMS1.3.2	**M**	Recommendations for improvement or required follow-up are recorded in the log.
SMS1.3.4	**M**	The log is signed by the person conducting the visit.
SMS1.4	**Roles of authority, responsibility and accountability are clearly defined and maintained at remotely supervised facilities.**	
SMS1.4.1	**M**	The medical leader or designated interpreting physician maintains ongoing communication with the technical staff and test requestors.
SMS1.4.2	**M**	Processes are in place to ensure the prompt availability of an interpreting physician for consultation whenever required.
SMS1.4.3	**M**	The medical leader documents those tests that may be performed at remotely supervised facilities.

Medical staff credentialing

Introduction

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

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

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

No.		Description
SMS2.0		**THE DIAGNOSTIC SERVICE HAS QUALIFIED AND COMPETENT MEDICAL PRACTITIONERS.**
SMS2.1		**Information for each medical practitioner is collected, verified and assessed relative to the requested scope of practice/procedure.**
		This information includes:
SMS2.1.1	**M**	• current licensure from the College of Physicians and Surgeons of British Columbia in the relevant specialty
SMS2.1.2	**M**	• MSP billing eligibility confirmation from the College of Physicians and Surgeons of British Columbia to bill for restricted services, if not affiliated with a health authority
SMS2.1.3	**M**	• relevant education and training
SMS2.1.4	**M**	• evidence of physical ability to perform the scope of practice/procedure
SMS2.1.5	**M**	• experience and competency to perform the scope of practice/procedure
SMS2.2		**Medical staff only practise within the scope of their privileges.**
SMS2.2.1	**M**	An accurate list of all medical practitioners practising within the diagnostic service is maintained.
SMS2.2.2	**M**	A record is maintained for each medical practitioner indicating the scope of service/procedures they are permitted to practice within the diagnostic service and this is communicated to the practitioner and the organization.
SMS2.3		**Polysomnography (PSG) services are provided by qualified and competent physicians.**

No.		Description
SMS2.3.1	**M**	Physicians providing adult or pediatric diagnostic polysomnography services 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 may require further training, experience and demonstrated skills. Refer to http://bcmqi.ca/privileging-dictionaries/ for the requirements to perform diagnostic polysomnography.*

Delegation of medical acts

No.		Description
SMS3.0		**THE DELEGATION OF MEDICAL ACTS DOES NOT COMPROMISE PATIENT SAFETY OR QUALITY.**
SMS3.1		**Delegated medical acts are clearly defined.**
SMS3.1.1	**M**	Each delegated medical act is clearly defined and circumscribed.
SMS3.1.2	**M**	The degree of medical supervision required is identified. *Guidance: Medical supervision may be direct, with the physician in attendance, or through technology (e.g. video link, telephone).*
SMS3.1.3	**M**	Competency requirements to perform the delegated medical act are clearly identified.
SMS3.2		**The delegation of medical acts has been approved and accepted.**
SMS3.2.1	**M**	There is consensus from the medical community that the delegation of the medical act is appropriate.
SMS3.2.2	**M**	The delegation of the medical act has been accepted by the individual(s) who will perform the delegated medical act.
SMS3.2.3	**M**	Agreement from the governing body/ownership of the organization has been obtained prior to the delegated medical act being carried out in the organization.
SMS3.3		**Delegated medical acts are performed by competent individuals.**
SMS3.3.1	**M**	Additional training is provided to individuals performing the delegated medical act.
SMS3.3.2	**M**	An assessment of the competence of the individual to perform a specific act is conducted by a physician. *Guidance: The physician conducting the assessment should have the relevant expertise in the medical act.*
		The record of the assessment of competence for each individual:
SMS3.3.3	**M**	• identifies the name of the individual

No.	Description	
SMS3.3.4	**M**	• the date of the assessment
SMS3.3.5	**M**	• the specific act(s) being assessed
SMS3.3.6	**M**	• the name of the physician conducting the assessment
SMS3.3.7	**M**	• the signature of the physician attesting to the competence of the individual performing the specific act(s)
SMS3.3.8	**M**	Maintenance of competency of the individual performing the specific act(s) is reassessed annually by a physician with relevant expertise in the medical act.
SMS3.3.9	**M**	The record of assessment of competence for each individual is updated annually to record the reassessment.
SMS3.4	**The organization maintains documentation of delegated medical acts.**	
SMS3.4.1	**M**	The diagnostic service maintains a list of approved medical acts that have been delegated.
SMS3.4.2	**M**	A list of individuals authorized to conduct specific delegated medical acts is maintained.

Human resources

Introduction

The management of human resources encompasses the policies, procedures and systems that influence the behaviour and performance of staff. 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 in the department.

There is 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.

Staff selection and retention

No.		Description
SHR2.0		**THE DIAGNOSTIC SERVICE HAS PROCEDURES IN PLACE TO SELECT AND RETAIN QUALIFIED AND COMPETENT STAFF.**
SHR2.1		**The diagnostic facility has qualified and competent staff to deliver services.**
SHR2.1.1		The diagnostic facility selects and recruits staff based on qualifications and experience (e.g. certification, academic preparation, knowledge, skills and reference checks).
SHR2.1.2	**M**	Technical staff providing polysomnography services are certified by the Board of Registered Polysomnographic Technologists (BRPT); **or**
SHR2.1.3	**M**	Technical staff providing polysomnography services are certified as registered polysomnographic technologists (RPSGT); **or**
SHR2.1.4	**M**	Technical staff providing polysomnography services are graduates of an accredited training school of polysomnography and are eligible to undergo examination from the Board of Registered Polysomnographic Technologists (BRPT).

Staff roles and records

No.		Description
SHR3.0		**THE STAFF AND LEADERSHIP OF THE DIAGNOSTIC SERVICE UNDERSTAND THEIR ROLES AND ACCOUNTABILITIES.**
SHR3.1		**Job descriptions exist for all staff.**
SHR3.1.1	**M**	There are job descriptions for all staff that reflect current practice and evolving responsibilities.

Staff orientation and training

No.		Description
SHR5.0		**ORIENTATION, TRAINING AND CONTINUING EDUCATION FOR THE SAFE PROVISION OF QUALITY DIAGNOSTIC SERVICES IS PROVIDED.**
SHR5.1		**New staff receive orientation and training appropriate for their job position.**
		New staff receive orientation and training that includes:
SHR5.1.1	**M**	• patient safety (e.g. definitions and reporting processes for adverse events and critical incidents)
SHR5.1.2	**M**	• patient identification
SHR5.1.3	**M**	• management of infectious materials including routine precautions, needle stick, injury protocol and personal protective equipment
SHR5.1.4	**M**	• sharps handling and disposal
SHR5.1.5	**M**	• WHMIS (e.g. appropriate disposal of solutions and supplies)
SHR5.1.6	**M**	• staff injury prevention and reporting
SHR5.1.7	**M**	• fire safety
SHR5.1.8	**M**	• management of aggressive behaviour
SHR5.1.9	**M**	• violence and harassment in the workplace
SHR5.1.10	**M**	• emergency responses/codes
SHR5.1.11	**M**	• disaster response

No.	Description	
SHR5.1.12	**M**	• information management processes and systems
SHR5.1.13	**M**	• confidentiality of data and information
SHR5.1.14	**M**	• relevant policies and procedures related to performing the duties of the position
SHR5.1.15	**M**	• roles and responsibilities of the individual and key staff

Patient and client focus

Introduction

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

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

Management of patient and client relationships

No.	Description
SPC1.0	**THE DIAGNOSTIC SERVICE SEEKS TO UNDERSTAND AND BE RESPONSIVE TO THE REQUIREMENTS OF PATIENTS AND CLIENTS.**
SPC1.2	**Service standards of the diagnostic service are defined and communicated to patients and clients.**
SPC1.2.2	**M** There is a process for patient prioritization.

General safety

Occupational health and safety

The accreditation standards relating to occupational health and safety includes those most critical to staff safety in the diagnostic service; however, they do not encompass all of the requirements under the *Workers Compensation Act* of British Columbia. Leaders 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.

Management responsibilities

No.		Description
SSA1.0		**POTENTIAL HAZARDS AND RISKS TO STAFF, PATIENTS AND VISITORS ARE MINIMIZED.**
SSA1.1		**There is a safety program in place that includes:**
SSA1.1.1		• the engagement of staff *Guidance: All diagnostic service staff are encouraged to become involved in the safety program through the sharing of responsibilities, participation in audits, representation on a safety committee, etc.*
SSA1.1.2	**M**	• monthly safety audits/inspections of the work area, equipment, and practices to identify and resolve safety hazards *Guidance: Occupational health and safety regulations require safety audits/inspections to be conducted at least once per month and these audits must be reviewed by the occupational health and safety committee or health and safety representative.*
SSA1.2		**A safety manual is readily available to staff that includes:**
SSA1.2.1	**M**	• how to access first aid services and/or medical assistance for staff related injuries *Guidance: If the diagnostic service is part of a larger facility (over 50 staff), there must be immediate access to an Occupational First Aid Attendant (OFAA) with a minimum of a level 2 occupational first aid certificate. If the facility is self-contained, a level 1 OFAA is sufficient until the total staff surpasses 50. Detailed tables specifying the first aid requirements are found in the Occupational Health and Safety Regulation at the end of Part 3. It must be noted that medical facilities are NOT exempt from these requirements. Medical facilities may have staff take the appropriate OFA course but some leeway is provided to allow for existing qualification to be considered equivalent.*

No.	Description	
SSA1.2.2	**M**	• the policy and procedure for investigating and reporting staff safety incidents including near misses
SSA1.2.3	**M**	• exposure control plans, based on existing occupational hazards
SSA1.2.4	**M**	• requirements for the use of personal protective and other safety equipment
SSA1.2.5	**M**	• Workplace Hazardous Materials Information System (WHMIS) program information
SSA1.2.6	**M**	• emergency evacuation plans
SSA1.2.7	**M**	• 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.*
SSA1.2.8	**M**	• procedures to manage violent and aggressive behaviour *Guidance: The procedure for dealing with the prevention of, and response to, incidents of violence must distinguish between incidents involving two workers ("improper conduct") and incidents of aggressive behaviour from a patient or member of the public ("violence"). All incidents of improper conduct and violence must be formally investigated, whether any injury occurred or not.*
SSA1.3	**Safety issues are discussed and monitored.**	
SSA1.3.1	**M**	The diagnostic service has a safety committee or health and safety representative. *Guidance: If there are 20 or more employees, a joint occupational health and safety committee (JOHSC) must be functioning. If the diagnostic service is part of a larger facility, a member of the committee must have the responsibility to represent the diagnostic service. If the facility has between 10 and 19 staff, the workers must select a person to be their Health and Safety Representative. This person, in effect, carries out the same functions as the committee in a larger facility. For organizations with less than 10 employees, the employer is required to hold regular meetings with the staff to discuss matters relating to maintaining a healthy and safe workplace. Records of these meetings must be kept. Sections 125 to 140 of the Workers Compensation Act provide all the details about committee requirements and function.*

Safe practices and equipment

No.	Description	
SSA1.4	**Chemicals are used, stored and disposed of safely.**	
SSA1.4.1	**M**	Hazardous liquids such as corrosives are stored below eye level.
SSA1.4.2	**M**	Containers for flammable liquids are kept as small as possible.
SSA1.4.3	**M**	Containers for flammable liquids are kept closed when not in use.

No.		Description
SSA1.4.4	**M**	Flammable liquids are stored in approved cabinets. *Guidance: Refer to the product* Material Safety Data Sheets (MSDS) *for handling and storage.*
SSA1.4.5	**M**	MSDS is available and current for controlled substances subject to WHMIS regulations.
SSA1.4.6	**M**	Controlled substances are labeled appropriately. *Guidance: This applies to both the original supplier issued container and any secondary containers that have a workplace label indicating: product name; safe handling procedures; and reference to MSDS.*
SSA1.6		**Fire safety measures are implemented.**
SSA1.6.1	**M**	Appropriate fire extinguishing equipment and procedures are in place.
SSA1.7		**Electrical safety measures are implemented.**
SSA1.7.1	**M**	Equipment complies with electrical safety regulatory requirements (e.g. Canadian Standards Association (CSA) or equivalent).
SSA1.8		**Personal protective equipment is available for staff.** *See also Infection Prevention and Control Accreditation Standards.*
SSA1.8.1	**M**	Adequate and appropriate personal protective equipment is available to protect staff from chemical or biological hazards. *Guidance: Personal protective equipment may include gloves, lab coats/gowns and masks.*
SSA1.8.2	**M**	Latex-free gloves are available to staff with latex sensitivities.
SSA1.9		**There are mechanisms in place to prevent staff from assuming postures that could result in musculoskeletal injuries.**
SSA1.9.1	**M**	Work place and equipment positioning reduce the risk of ergonomic distress disorders and accidents. *Guidance: If workers experience symptoms indicating a musculoskeletal injury, the employer must investigate and make appropriate changes to the work area.*
SSA1.9.4	**M**	Adequate assistance and transfer/lift devices are available when moving or lifting patients. *Guidance: Transfer/lift devices include "transavers," slider boards and ceiling or mobile patient lifts.*
SSA1.9.5	**M**	The weight limit of lifting equipment is clearly marked.

Appropriate physical environment

No.	Description
SSA2.0	**THE DESIGN AND LAYOUT OF THE PHYSICAL SPACE ALLOWS SERVICE DELIVERY TO BE SAFE, EFFICIENT AND ACCESSIBLE FOR PATIENTS, VISITORS AND STAFF.**
SSA2.1	**The design and layout of the physical space meets laws, regulations and codes.**
SSA2.1.2	**M** Emergency exit routes are marked and provide an unimpeded exit.
SSA2.3	**The physical environment ensures patient safety and privacy.**
SSA2.3.1	**M** Patient areas are safe and clean.
SSA2.3.5	**M** Patient information cannot be viewed by other patients or visitors.
SSA2.3.6	**M** Patient privacy is not compromised during the diagnostic procedure.
SSA2.5	**The physical environment meets the needs of staff.**
SSA2.5.4	M Storage and consumption of food and beverages is permitted in designated areas only.
SSA2.6	**Sinks and eyewashes are available to staff.**
SSA2.6.1	**M** There are clearly labeled hand washing sinks.
SSA2.6.2	**M** Hand washing sinks have unimpeded drainage (e.g. not stoppers).
SSA2.6.4	**M** Eyewash stations are conveniently located and regularly flushed, when appropriate. *Guidance: Consult with WorkSafeBC to determine the type of eyewash station required based upon the chemicals used in the diagnostic service.*
SSA2.7	**Lighting, temperature and ventilation is appropriate.**
SSA2.7.1	**M** Lighting provides sufficient illumination for safe working.
SSA2.7.2	**M** Emergency lighting is available in the event of power failure. *Guidance: Emergency lighting units must be tested regularly.*

Patient safety

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.

Creating a culture of patient safety

No.		Description
SPS1.0		**THE DIAGNOSTIC SERVICE CREATES A CULTURE OF PATIENT SAFETY AND MAKES PATIENT SAFETY A PRIORITY.**
SPS1.2		**The activities of the diagnostic service ensure patient safety.**
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).*

Patient identification

No.		Description
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.**
SPS2.1.3	**M**	At least two unique patient identifiers are used when verifying patient identification.
SPS2.1.6	**M**	Pediatric and other patients who cannot provide identification information are identified by a responsible adult.
SPS2.1.7	**M**	Patient identity discrepancies are resolved prior to testing.

Medication management and administration

No.	Description
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.
SPS3.1.2	**M** All stored medications are labeled with the contents, expiration date, and any warnings as applicable.

Risk and disclosure

No.	Description
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.**
SPS4.1.3	**M** All adverse events and critical incidents are documented.
SPS4.1.4	**M** Policies and procedures for reporting, investigating and making recommendations following a near miss are documented and available to staff.

Medical emergencies

No.	Description
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.
SPS5.1.2	**M** Staff are familiar with the procedure(s) for responding to medical emergencies.
SPS5.1.3	**M** The facility identifies staff who respond to emergencies and provides training in the use of emergency equipment.

No.		Description
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.).*
		Staff know how to access:
SPS5.1.5	**M**	• emergency medical services
SPS5.1.6	**M**	• emergency equipment and supplies

Infection prevention and control

Introduction

Facilities establish infection prevention and control activities and precautions to 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 facility, the resources available, the services provided, and the patients served.

Planning

No.	Description
SIPC1.0	**PLANNING FOR INFECTION PREVENTION AND CONTROL IS EFFECTIVE, INTEGRATED AND COORDINATED.**
SIPC1.1	**An infection prevention and control plan is developed and implemented.**
SIPC1.1.1	**M** There are documented policies and procedures for infection prevention and control (e.g. an infection control manual).

Fully implement the requirement within three months.

Routine practices

No.	Description
SIPC2.0	**ROUTINE PRACTICES FOR PREVENTING THE TRANSMISSION OF INFECTION ARE IMPLEMENTED.** *Guidance: The term "routine practices" (or "standard precautions") is used to describe a system to prevent transmission of infections in health-care settings. These practices are to be used at all times, with all patients regardless of diagnosis or infectious status.*
SIPC2.1	**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.*
SIPC2.1.7	**M** There are sufficient, readily accessible, designated hand hygiene sinks or other accessible forms of hand hygiene products.

No.	Description
SIPC3.0	**PERSONAL PROTECTIVE EQUIPMENT (PPE) IS WORN BY STAFF AS A BARRIER AGAINST BLOOD AND BODY FLUID EXPOSURE.** *Guidance: See also General Safety Accreditation Standards.*
SIPC3.3	**The diagnostic service has a process for the assessment and use of a N95 respirator/mask.**
SIPC3.3.1	**M** A risk assessment is conducted to determine if and when the use of N95 respirators/masks for staff is necessary. *Intent: An N95 respirator/mask helps protect staff from respiratory pathogens that are transmitted via the airborne route. Staff must use N95 respirators/masks if they may be exposed to an airborne infection that is listed in the WorkSafeBC Regulations and a risk assessment has indicated that this infection poses a potential hazard. It is recommended that the diagnostic service consults with Occupational Health and Safety (OH&S) and infection control resources regarding conducting the risk assessment.*

Additional precautions

No.	Description
SIPC4.0	**PATIENTS, STAFF AND VISITORS ARE PROTECTED FROM POTENTIAL OR KNOWN COMMUNICABLE DISEASES.**
SIPC4.1	**Additional precautions are used for patients with known or suspected communicable diseases.** *Intent: Additional infection prevention and control precautions are necessary for specific pathogens or clinical presentations. Professional knowledge, skills and judgment are used to assess the potential routes of transmission and the appropriate additional precautions to be taken (e.g. contact, droplet or airborne precautions).*
SIPC4.1.6	**M** N95 respirators/masks are available for all staff who enter the procedure room if there is a known, or suspected airborne infection. *Guidance: Airborne transmission refers to transmission of infection by inhaling aerosols e.g. tuberculosis, measles, or chicken pox (varicella). This can occur when a patient coughs, sneezes, or talks. These infectious agents can be acquired by susceptible individuals who may be at some distance away from the source patient.*
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.**
SIPC4.2.1	All staff are aware of and have documentation of their vaccination history, medical history, or serologic test results.

No.		Description
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.*

SIPC5.0 BLOOD AND BODY FLUID EXPOSURE PRECAUTIONS ARE USED TO SAFEGUARD STAFF.

SIPC5.2		**Safe and effective practices are followed for the use and disposal of sharps.**
SIPC5.2.3	**M**	Used sharps are disposed of immediately in designated puncture resistant containers located in the immediate area where the sharp was used. *Guidance: In areas where sharps containers have not been mounted, portable sharps containers are used.*

Cleaning of surfaces and ancillary medical equipment

No.		Description

SIPC6.0 THE PHYSICAL ENVIRONMENT OF THE DIAGNOSTIC SERVICE IS CLEAN.

SIPC6.1		**Safe and effective cleaning of the physical environment is maintained.**
SIPC6.1.1	**M**	Policies and procedures are in place indicating the frequency and method of environmental cleaning and disinfection.
SIPC6.2		**The diagnostic service reduces the risk of infections associated with ancillary medical equipment.**
SIPC6.2.1	**M**	Routinely used patient testing equipment (e.g. tourniquets) are cleaned or discarded between patients.
SIPC6.2.2	**M**	Single-use medical devices are not reprocessed. *Intent: The reuse of single-use devices can affect their safety, performance, and effectiveness and expose patients and staff to unnecessary risk.*

Information management

Introduction

The diagnostic service generates management and clinical information that must be managed. 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 generated by the diagnostic service to ensure staff and clients have access to necessary and appropriate information.

Planning

No.		Description
SIM1.0		**PLANS FOR MANAGING CLINICAL AND MANAGEMENT INFORMATION ARE EFFECTIVE, INTEGRATED AND COORDINATED.** *Intent: Planning is one of the most critical components of information management and requires the collaborative involvement of all levels and areas of the organization. Planning includes the assessment of the system and resources necessary to implement and maintain the current and future information needs of the diagnostic service.*
SIM1.3		**Users of information systems and processes (including paper-based) are provided training appropriate for their roles and responsibilities.**
SIM1.3.1	**M**	Training for users is provided prior to the use of information systems.
SIM3.0		**CONTINUITY OF INFORMATION MANAGEMENT PROCESSES ENSURES THE AVAILABILITY OF INFORMATION.**
SIM3.1		**The diagnostic service is prepared for events that could impact the availability of information.**
SIM3.1.1	**M**	There is a documented disaster recovery plan and associated risk assessment for recovery and access to data. *Guidance: For paper-based systems, the documented recovery plan should be more basic than for computerized systems.*
SIM3.1.3	**M**	For computerized systems, database backup is performed daily and the backup is securely located in a separate physical location.
SIM3.1.4	**M**	Data stored on-site and off-site is accessible, but protected from unauthorized access and safeguarded against harm (e.g. water, fire, etc.).

No.	Description
SIM3.2	**Downtime procedures are available and communicated to staff.** *Intent: Downtime procedures are required for both scheduled and unscheduled system downtime.*
SIM3.2.2	**M** Users know how to contact support staff in the event of system and/or equipment malfunction.

Confidentiality

Introduction

Privacy of health information applies to electronic, paper, and verbal communications. Protecting the privacy of health information is the responsibility of all staff. Organizations protect privacy by limiting the use of information to only what is needed to provide care, treatment, or services.

A confidentiality violation occurs when an individual is able to bypass security measures and systems to gain access to health information.

No.	Description
SIM4.0	**THE DIAGNOSTIC SERVICE PROTECTS THE CONFIDENTIALITY OF DATA AND INFORMATION.**
SIM4.1	**Patient confidentiality and information is protected through policies and procedures.** *References: Freedom of Information and Protection of Privacy Act for the public sector and the BC Personal Information Protection Act for the private sector.* *Intent: Security and confidentiality of personal information must be protected when using electronic information systems. Network and software security protocols are required to protect the confidentiality of diagnostic reports and other data.*
SIM4.1.1	**M** Data access is restricted, controlled and monitored.
SIM4.1.2	**M** Policies are in place that specify the level of access that is permitted for each category of staff, including information recorded in patient files from other service areas in the organization. *Intent: Personal information is accessed only by those who are engaged in the primary purpose for which the information was captured.*
SIM4.1.3	**M** Authorized staff maintain user access and restriction controls.
SIM4.1.5	**M** There is a policy that addresses how to handle unauthorized users.
SIM4.1.6	**M** For computer-based systems there is a policy for password confidentiality and use.
SIM4.1.7	**M** Generic login accounts are not used.

No.		Description
SIM4.1.8	**M**	There is a procedure that ensures linkage between test data and patient identification is removed before any secondary use is permitted (e.g. records used for research or teaching purposes are anonymized).
SIM4.2		**The service has policies for the release or destruction of data.**
		There is a policy for the use and disclosure of personal information:
SIM4.2.1	**M**	• to patients
SIM4.2.2	**M**	• to family members
SIM4.2.3	**M**	• to health-care professionals
SIM4.2.4	**M**	• to other service areas within the organization
SIM4.2.5	**M**	• to other organizations
SIM4.2.6	**M**	• for research and education purposes
SIM4.2.7	**M**	• for legal reasons
		There is a policy that identifies personal information that can be distributed by the following:
SIM4.2.8	**M**	• electronic mail
SIM4.2.9	**M**	• facsimile
SIM4.2.10	**M**	• web-based technology

Medical records

Introduction

The medical record is an important method of communication for all members of the health-care team. The patient's medical record contains all the clinical data and information related to the patient's diagnostic procedures. The patient's medical record functions not only as a historical record of a patient's diagnostic procedure, but also as a method of communication between physicians and staff. These records facilitate the continuity of care and aid in clinical decision-making. Medical records may be one component of the facility's health record.

No.	Description
SIM5.0	**THE DIAGNOSTIC SERVICE MAINTAINS COMPLETE AND ACCURATE MEDICAL RECORDS.** *See also Global Accreditation Standard, GS 4.0.*

No.		Description
SIM5.1		**The medical record includes accurate patient identification information.**
SIM5.1.1	**M**	The facility 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 facility 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.*
SIM5.1.2	**M**	The patient name, patient identifying number and facility name are clearly identified on the master file/patient medical record. *Guidance: The master patient file is appropriately identified for paper-based systems and the medical record for electronic systems.*

Retention of documents and records

Refer to the Ministry of Justice of British Columbia for additional information, accessible at http://www.ag.gov.bc.ca/legislation/limitation-act/2012.htm.

No.		Description
SIM7.0		**THE DIAGNOSTIC SERVICE RETAINS DOCUMENTS AND RECORDS.**
SIM7.1		**Medical records are stored according to British Columbia's revised *Limitation Act* (2013).**
SIM7.1.1	**M**	Medical records are stored according to the British Columbia's revised Limitation Act. *Guidance: The medical record comprises all the clinical data and information related to the patient's diagnostic procedure. The medical record contains all relevant documents for testing including, but not limited to: the request, hard copy or electronic worksheets and reports. Facilities and medical leaders establishing retention times outside of the requirements of the Limitation Act should seek and act according to expert legal advice on this matter.*
SIM7.1.2	**M**	Pediatric record and diagnostic report retention complies with adult retention criteria, in addition to "past the age of majority."

Equipment and supplies

Introduction

General manufacturers of equipment will provide installation, verification and maintenance requirements that must be followed to ensure adequate equipment functionality.

Equipment

No.	Description
SES1.0	**EQUIPMENT IS SAFELY OPERATED, MAINTAINED AND MONITORED IN A MANNER THAT ENSURES PERFORMANCE SPECIFICATIONS ARE MET.**
SES1.1	**There is a current inventory for all equipment used in the diagnostic chain that includes:**
SES1.1.1	**M** • name of item
SES1.1.4	**M** • date of installation
SES1.1.5	**M** • condition of equipment at the time it was acquired (e.g. new, refurbished)
SES1.2	**Diagnostic equipment is appropriately operated.**
SES1.2.1	**M** An orientation and training program is provided for all equipment to ensure safe, consistent, and accurate operation.
SES1.2.4	**M** Equipment operators have access to the manufacturer's operator manual for the specific equipment used in the facility.
SES1.2.5	**M** All equipment is located and stored in a safe and secure location.
SES1.3	**The diagnostic service investigates and resolves problems involving all equipment.**
SES1.3.2	**M** There is a list of service staff and their contact information.
SES2.0	**EQUIPMENT TESTING IS PERFORMED PRIOR TO CLINICAL USE.**
SES2.1	**Safety testing is performed after purchase and prior to clinical use of equipment.**
SES2.1.1	**M** New, replaced, or relocated equipment has safety testing performed prior to clinical use.
SES2.1.2	**M** The tester is independent of the manufacturer.

Solutions and supplies

No.	Description
SES3.0	**SOLUTIONS AND SUPPLIES ARE MONITORED IN A WAY THAT REDUCES OR ELIMINATES SHORTAGES AND WASTE.**
SES3.1	**The storage and monitoring of solutions and supplies ensures an effective inventory control system.**
SES3.1.1	**M** Storage complies with manufacturer's recommendations.

Global polysomnography

The global accreditation standards are to be used in conjunction with the category specific accreditation standards.

Test Requests

No.	Description	
GS1.0	**TEST REQUESTS ARE STANDARDIZED AND ENSURE THAT ACCURATE, COMPREHENSIVE AND APPROPRIATE INFORMATION IS RELAYED.** *Guidance: Requests are to be completed for all diagnostic tests. Requests may be verbal, written (requisitions) or electronic.*	
GS1.3	**Requests contain accurate and appropriate information that includes:**	
GS1.3.1	**M**	• the patient's first and last name
GS1.3.2	**M**	• a unique personal identifier number such as provincial health number (PHN) or facility–issued identifier number
GS1.3.3	**M**	• date of birth
GS1.3.4	**M**	• gender
GS1.3.5	**M**	• name and contact information of authorized individual *Intent: If an urgent/stat report is required the authorized individual's contact information is provided.*
GS1.3.6	**M**	• clear indication of the authorized individual
GS1.3.7	**M**	• name(s) of any other individual who is to receive a copy of the report
GS1.3.8	**M**	• test type(s) and any specific instructions
GS1.3.9	**M**	• pertinent clinical information including indications, history, and provisional diagnosis *Intent: The clinical information is sufficient to ensure the appropriate test is performed. Provisional diagnosis is provided when applicable to assist in determining the most appropriate diagnostic test.*
GS1.3.10	**M**	• the date the request is received
GS1.3.11	**M**	• indication of urgency *Intent: There is an effective system in place to ensure patient prioritization. For emergent patient prioritization cases the urgency is indicated on the request either by the authorized individual and/or by the diagnostic physician or designate.*

Patient preparation

No.	Description
GS2.0	**PATIENTS ARE APPROPRIATELY PREPARED FOR THE TEST BEING PERFORMED.**
GS2.2	**Pre-test information is collected and assessed prior to commencing the test.**
GS2.2.2	**M** Processes ensure relevant prior tests are available for comparison. *Guidance: The criteria to obtain relevant prior tests are clearly defined by the medical leader to ensure processes are followed. In some instances relevant prior tests will need to be requested from external organizations.*
GS2.2.4	**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 care giver concerning the patient's condition and any limitations.*

Procedures and documentation

No.	Description
GS3.0	**STANDARDIZED PROCEDURES ARE USED IN DIAGNOSTIC FACILITIES TO OBTAIN TEST RESULTS.**
GS3.2	**The diagnostic facility ensures documentation is available to ensure consistency of testing.** **Guidance: Documentation includes both electronic and paper-based systems.**
GS3.2.1	**M** All procedures are documented, communicated to, and available to staff performing the testing.
GS3.2.2	**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, special safety precautions, expected values or results (normative values).*

Medical record

No.	Description
GS4.0	**THE MEDICAL RECORD IS CURRENT, ACCURATE AND CONTAINS RELEVANT TEST DETAILS.**

No.	Description	
GS4.1	**Tests are labeled in a standardized way that allows for proper patient identification that include:**	
GS4.1.1	**M**	• patient first and last name
GS4.1.2	**M**	• second patient identifier (e.g. identifying number or date of birth)
GS4.1.3	**M**	• facility name
GS4.1.4	**M**	• date and time of test
GS4.1.5	**M**	• name of requesting physician
GS4.1.6	**M**	• identification of recording individual (e.g. name or initials or other)
GS4.1.7		• patient's gender
GS4.2	**Comprehensive test details are recorded in the medical record that includes:** *Intent: Test details may be recorded electronically or on written requisitions/worksheets. All details are made available to the interpreting physician.*	
GS4.2.1	**M**	• the patient requisition (paper or electronic format)

Interpretation and reports

No.	Description	
GS5.0	**DIAGNOSTIC REPORTS ARE IN A STANDARDIZED FORMAT THAT PROVIDES COMPREHENSIVE AND NECESSARY INFORMATION FOR CLINICAL DECISION-MAKING.**	
GS5.1	**Reports are comprehensive and include appropriate patient and relevant clinical information.**	
	Reports include the following information:	
GS5.1.1	**M**	• the patient's first and last name
GS5.1.2	**M**	• a unique personal identifier number such as PHN or facility-issued identifier number
GS5.1.3	**M**	• date of birth
GS5.1.4	**M**	• gender
GS5.1.5		• facility name
GS5.1.6	**M**	• test performed
GS5.1.7	**M**	• name of authorized individual requesting test

No.	Description	
GS5.1.8	**M**	• the individual performing the test (e.g. name or unique identifier)
GS5.1.9	**M**	• report recipient(s)
GS5.1.10	**M**	• date of the test
GS5.1.11	**M**	• the time of test, if relevant (e.g. patients likely to have more than one test type per day)
GS5.1.12	**M**	• date of interpretation (e.g. dictation and/or transcription) *Intent: Having both dates may be useful to some facilities when determining report turnaround times.*
GS5.1.13	**M**	• report status (e.g. preliminary or final)
GS5.1.14	**M**	• multiple page reports include patient identifiers on each sequentially numbered page

Reporting processes

No.	Description
GS6.0	**EFFECTIVE COMMUNICATION MINIMIZES THE RISKS OF BOTH REPORTING AND PATIENT MANAGEMENT ERRORS.** *Intent: Effective communication is tailored to satisfy the need for timeliness, support the role of a diagnostic physician and minimize the risk of communication errors. The authorized individual or relevant health-care provider shares in the responsibility for obtaining results of diagnostic tests he or she has requested.*
GS6.2	**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 hospital or the diagnostic service. 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.*

No.	Description	
GS6.2.1	**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.

Polysomnography

Introduction

In addition to the global polysomnography accreditation standards, these specific accreditation standards for polysomnography provide additional mandatory requirements and best practices for accreditation.

Procedures

No.	Description
PSG2.0	**NOCTURNAL TESTS ARE COMPREHENSIVE AND PROVIDE ALL THE NECESSARY INFORMATION.**

Overnight sleep test – polysomnogram (PSG)

PSG2.1	**Overnight sleep tests are standardized and recorded in a manner to ensure accurate results for interpretation.**
PSG2.1.6	**M** Monitoring equipment ensures that each patient can be monitored without unavoidable interruption and allow patients to communicate with technical staff in the event they require assistance.

Pediatric PSG

PSG2.2	**Pediatric testing is standardized and recorded in a manner that ensures accurate results for interpretation.** *Guidance: Pediatric testing is performed using the same general procedures as for adults. However, age-appropriate factors are considered when performing overnight sleep tests.*
PSG2.2.1	**M** The technical staff members have training and experience in dealing with children.

Split-night PSG

PSG2.3	**Split-night sleep tests are standardized and recorded in a manner that ensures accurate results for interpretation.** *Guidance: A split-night PSG in not just limited to PAP therapy. It may also involve therapies such as supplemental oxygen, oral appliance/adjunct therapy (e.g. nasal splint), positional or medication.*
PSG2.3.4	**M** A minimum two hour baseline is obtained. *Intent: A baseline is required in order to capture the first REM period.* *Guidance: Split-night testing may be initiated earlier with patients that have severe apnea.*

No.		Description
PSG2.3.6	**M**	Guidelines for converting to CPAP titration or adjunct therapy are defined.

Positive airway pressure titration (PAP)

No.		Description
PSG2.4		**PAP titration tests are standardized and recorded in a manner that ensures accurate results for interpretation.**
		Titration guidelines are defined for:
PSG2.4.4	**M**	CPAP titration
PSG2.4.5	**M**	supplemental oxygen
PSG2.4.6	**M**	adapted servoventilation (ASV)
PSG2.4.7	**M**	average volume assured pressure support ventilation (AVAPS)

PSG4.0 AMBULATORY TESTS ARE COMPREHENSIVE AND PROVIDE ALL THE NECESSARY INFORMATION.

Overnight oximetry

No.		Description
PSG4.1		**Overnight oximetry tests are conducted and recorded in a manner that ensures accurate results.**
PSG4.1.5	**M**	There is a process to ensure the battery will last for the duration of the test. *Intent: This is done to ensure that oximetry testing is not compromised by dead batteries.*

PSG analysis and scoring

No.		Description

PSG10.0 POLYSOMNOGRAPH ANALYSIS AND TECHNICAL SUMMARY IS CONDUCTED IN A WAY THAT ENSURES MEANINGFUL, RELEVANT AND ACCURATE DATA IS REPORTED.

PSG10.1		**Analysis of the PSG includes scoring of the data.**
PSG10.1.1	**M**	The PSG data is scored manually.

No.		Description
PSG10.1.2	**M**	There are documented procedures which include the definition of sleep parameters, criteria, and events.
PSG10.1.3	**M**	A standardized definition of hypopnea is defined, documented and located on the report.
PSG10.1.4	**M**	A standardized definition of desaturation or desaturation index is defined, documented and located on the report.
PSG10.1.5	**M**	Audio/video monitoring and recording of the PSG is available for scoring/analysis.
PSG10.1.6	**M**	Scoring of sleep is done per 30 second epoch.
		Scoring of sleep includes:
PSG10.1.7	**M**	• periods of awake time (Stage W)
PSG10.1.8	**M**	• Stage N1 (S1)
PSG10.1.9	**M**	• Stage N2 (S2)
PSG10.1.10	**M**	• Stage N3 (S3/4)
PSG10.1.11	**M**	• Stage REM
PSG10.1.12	**M**	• arousal
PSG10.1.13	**M**	• obstructive apnea
PSG10.1.14	**M**	• central apnea
PSG10.1.15	**M**	• hypopnea
PSG10.1.16	**M**	• periodic limb movements (PLMS) with arousals
PSG10.1.17	**M**	• periodic limb movements (PLMS) without arousals
PSG10.1.18	**M**	• a comment on snoring
PSG10.1.19	**M**	• a comment on the type of breathing (e.g. Cheyne Stokes breathing)
PSG10.1.20		• number of respiratory effort related arousals (RERAs), if applicable *Guidance: When scoring for RERAs it is the arousals that needs to be counted and not the reduction in airflow.*
PSG10.1.21		• Respiratory Effort Related Arousal Index, if applicable

Technical summary

PSG10.2	**The technical summary report is standardized in a way that ensures meaningful, relevant and accurate data is reported.**

No.		Description
PSG10.2.1	**M**	A technical description of the PSG test that includes any unexpected observations, qualification of limb movements, snoring, breathing sounds, behaviours, etc.
PSG10.2.2	**M**	There is notation of individual performing the test.
PSG10.2.3	**M**	Comments on treatment modalities. *Guidance: Examples of treatment modalities include: oral appliance, type of CPAP mask, list of medications, physical limitations etc.*
		Sleep time documentation includes:
PSG10.2.4	**M**	• total time in bed (TIB; lights-out to lights-on)
PSG10.2.5	**M**	• sleep onset (lights out to first epoch of any sleep)
PSG10.2.6	**M**	• REM latency (sleep onset to first epoch of REM)
PSG10.2.7	**M**	• total sleep time (TST)
PSG10.2.8	**M**	• wake after sleep onset (including wake out of bed)
PSG10.2.9	**M**	• sleep efficiency (TST/TIB%)
PSG10.2.10	**M**	• time in each stage of sleep
PSG10.2.11	**M**	• percentage of TST in each stage of sleep
PSG10.2.12	**M**	• assessment of snoring
		Apnea/hypopnea documentation includes:
PSG10.2.13	**M**	• number of obstructive apneas
PSG10.2.14	**M**	• number of mixed apneas
PSG10.2.15	**M**	• number of central apneas
PSG10.2.16	**M**	• number of hypopneas
PSG10.2.17	**M**	• number of apneas plus hypopneas
PSG10.2.18	**M**	• Apnea Index
PSG10.2.19	**M**	• Hypopnea Index
PSG10.2.20	**M**	• Apnea plus Hypopnea Index (AHI)
PSG10.2.21		• RDIs (respiratory disturbance index), only if RERAs are scored
		Saturation (SpO_2) documentation includes:

No.	Description	
PSG10.2.22		• number of oxygen desaturations (>3 or 4%) • *Intent: The percent of desaturation should be clearly defined.*
PSG10.2.23		Oxygen desaturation index (>3 or 4%)
PSG10.2.24	**M**	• mean oxygen saturation
PSG10.2.25	**M**	• minimum oxygen saturation during sleep
PSG10.2.26	**M**	• duration or percentage of time spent below 88% for oxygen saturation
PSG10.2.27	**M**	• flow rate and type of delivery for supplemental oxygen
PSG10.2.28	**M**	• type of probe used to monitor saturation
		Pulse/heart rate documentation includes:
PSG10.2.29	**M**	• mean heart rate or pulse during sleep
PSG10.2.30	**M**	• maximum heart rate or pulse during sleep
PSG10.2.31	**M**	• minimum heart rate or pulse during sleep
PSG10.2.32	**M**	• suspected arrhythmia(s) are documented and the printout is provided to the interpreting physician
		Limb movement documentation includes:
PSG10.2.33		• occurrence of periodic limb movements of sleep (PLMS) without arousals
PSG10.2.34		• occurrence of PLMS with arousals
PSG10.2.35	**M**	• PLMS index
PSG10.2.36	**M**	• PLMS arousal index
PSG10.2.37	**M**	• total number of arousals and total arousal index
PSG10.2.38	**M**	• body position • *Intent: Notation or time spent in and out of the supine position.*
PSG10.2.39	**M**	• respiratory/ventilatory movement
		CO_2 monitoring documentation includes:
PSG10.2.40		• CO_2 is monitored via transcutaneous or caponometry *Guidance: Monitoring should be performed when ASV, BiLevel, AVAPS is being used or when hypoventilation is suspected.*

Glossary

Preamble

This glossary has been adapted from one provide 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. Some definitions have been imported from the Institute of Medicine and the Clinical Laboratory Standards Institute.

adverse events Can be defined in three ways:

- an unexpected and undesired incident directly associated with the care or services provided to the patient
- an incident that occurs during the process of providing health care and results in patient injury or death
- an adverse outcome for a patient, including injury or complication

critical incident An incident resulting in serious harm to the patient, or the significant risk thereof. Incidents are considered critical when there is an evident need for immediate investigation and response. The investigation is designed to identify contributing factors and the response includes action to reduce the likelihood of recurrence.

Medical Device Regulations Medical Device Regulations encompass all other safety considerations and the question of efficacy for **all medical equipment** sold in Canada. It is the responsibility of the manufacturer or distributor to ensure that the equipment conforms to the requirements of these regulations. Evidence of compliance includes an active Health Canada medical device licensing number.[1]

safety testing A process to verify compliance with the performance specifications of the equipment as written in the purchase contract. It also verifies that the equipment performance meets the manufacturer's specifications and complies with federal and provincial or territorial regulations.

Safety testing is to be performed prior to any clinical use of the equipment and performed by an individual with in-depth knowledge of the particular type of equipment and the relevant regulations. This individual is to be independent of the manufacturer.

References

Specific documents referenced

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