CPSBC COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

Diagnostic Accreditation Program

ACCREDITATION STANDARDS

Polysomnography

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

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

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

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

Understanding accreditation

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

Diagnostic imaging

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

Laboratory medicine

- sample collection, transport, accessioning and storage
- hematology
- chemistry
- transfusion medicine
- microbiology
- anatomic pathology
- point of care testing
- cytology
- cytogenetics

Neurodiagnostic services

- electroencephalography
- evoked potentials
- electromyography and nerve conduction studies

Pulmonary function

- hospital-based services
- community-based services

Polysomnography

Services and core functions

The DAP operates on a continuous quality improvement (CQI)model, and remains highly committed to supportive approaches to accreditation that foster the development of CQI cultures within the diagnostic services.

Core functions

Establishing accreditation programs targeted at specific diagnostic services

- Establishing optimal goals, standards, criteria and requirements

Establishing programs for assessor training and development

- Selecting skilled and appropriate assessors
- Providing orientation and training to assessors
- Evaluating and developing assessor performance
- Ensuring inter-rater reliability of assessors

Establishing processes of accreditation

- Establishing assessment activities required for accreditation
- Setting the criteria for awarding levels of accreditation
- Timely determination of accreditation decisions

- Establishing the duration and maintenance of accreditation
- Establishing a process for appeal of accreditation decisions
- Reporting accreditation status of organizations to the public

Establishing research and development, and education programs

- Generating and transferring new knowledge gained through the accreditation process
- Evaluating existing accreditation programs for relevancy and effectiveness
- Identifying the need and requirement for new accreditation programs, standards and/or criteria
- Collecting, analyzing, comparing, and publishing data
- Providing feedback on the performance of diagnostic services
- Acting as a resource centre for quality improvement standards, methods and experience, and as a focal point for the collection of local information, as well as for comparisons with other provinces and countries

Monitoring performance of organizations

- Selecting and mandating external proficiency testing programs;
- Establishing new external proficiency testing programs or approaches to monitoring process performance when there is no existing program available;
- Developing and monitoring robust quality indicators of performance

What is accreditation?

Accreditation is a process that assists diagnostic organizations/facilities/services to evaluate and improve the quality of the services they provide to their patients and clients. It is a process that allows for the identification of improvement opportunities leading to an improved quality of service. Accreditation also provides recognition that the organization/facility/service is meeting provincial standards of quality.

The founding principle of the Diagnostic Accreditation Program's model for accreditation is:

Enabling health-care organizations to review and improve systems that support the delivery of safe, high quality diagnostic care

The purpose of accreditation

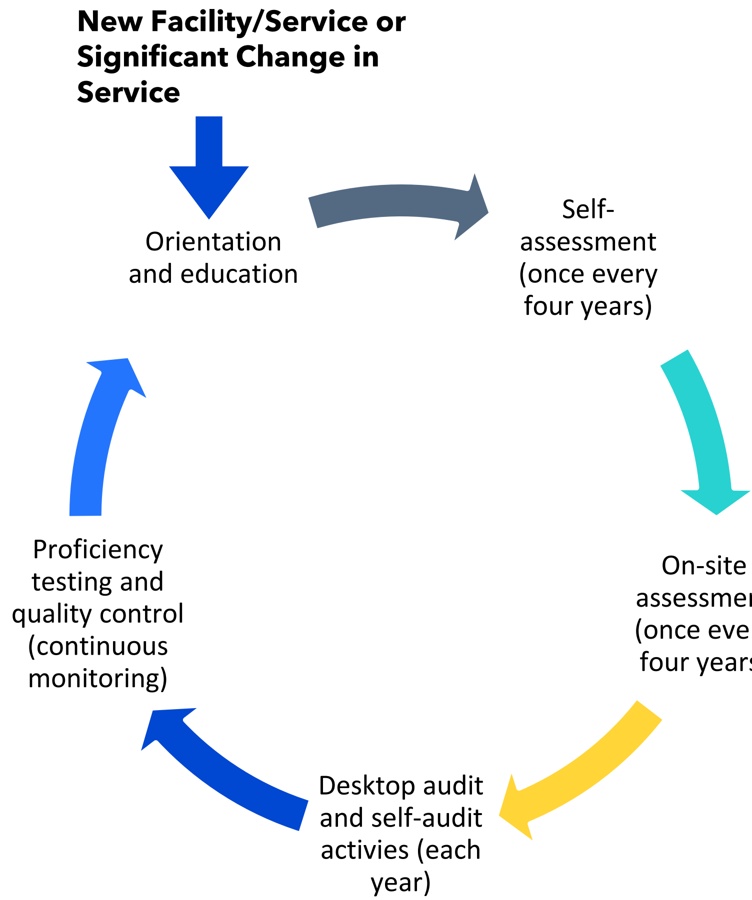
The purpose of accreditation is to provide the diagnostic service with a framework for continuous quality improvement:

- provides the diagnostic service with an opportunity to effectively evaluate itself against provincially set standards
- provides an external objective assessment of performance and comparison with similar diagnostic services
- identifies significant risk management issues
- assists diagnostic services to focus on key improvement opportunities
- disseminates the most effective practices amongst organizations
- promotes communication, collaboration and team work throughout the diagnostic service

Accreditation process

Accreditation assessment activities

DAP accreditation involves continuous assessment activities that take place during a four-year cycle. For new facilities and services, or services that have implemented a significant change, an initial assessment process has been developed that requires completion of specific documentation and an initial on-site visit by the DAP prior to services being provided to patients. Previously accredited facilities and services participate continuously in assessment activities throughout the four-year accreditation cycle.



New facility or new diagnostic service initial assessment

A new facility, new services provided by an accredited facility, or services that have implemented significant change proceed through the initial assessment process **prior** to service delivery to patients that includes:

- completion of documentation outlining facility service profile, equipment, individuals and related qualifications, etc.
- review of documentation and on-site visit by a DAP accreditation officer – in certain circumstances the accreditation officer may be accompanied by other external peer experts

If the facility/service is granted a provisional accreditation award, they are permitted to commence service delivery to patients subject to satisfactory performance in fulfilling continuous accreditation requirements. If the facility/service is not granted provisional accreditation, they are not permitted to commence service delivery to patients.

Self-assessment

The self-assessment is completed once in the four-year cycle and precedes the on-site assessment. Conducting a self-assessment enables the diagnostic service to evaluate their performance relative to stated standards and best practice. Assessing the diagnostic service's practices provides a profile of the strengths, risks, and opportunities for improvement. This is both a valuable process and tool to enable the management to focus continuous quality improvement efforts toward specific activities and take action with the creation of a quality improvement plan. The self-assessment also prepares the diagnostic service for the on-site assessment.

On-site assessment

The on-site assessment is completed once in the four-year cycle and is conducted by DAP accreditation officers. During the on-site assessment, the performance of the diagnostic service is assessed using patient and system tracers. This enables the accreditation officer(s) to assess the performance of the diagnostic service as staff is conducting patient examinations, studies and/or analysis. Detailed assessment protocols provide direction to the accreditation officer(s) outlining what to ask, observe, and assess. The use of protocols also assists with increasing the objectivity and consistency amongst accreditation officer(s). The tracer methodology has been used successfully by The Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations) and the DAP approach is based upon their experiences.

Desktop audit and self-audit activities

Throughout the four-year cycle, facilities will continue to provide assessment activity submissions to the DAP for the continuous monitoring and surveillance of performance. Examples of these assessment activities include:

- internal audit submissions of high-risk practices and clinical audits

- conducting of audits using infection control tracers, patient safety tracers, and clinical informatics tracers
- submission of performance indicator data
- evidence of implementation of selected accreditation standards that are best assessed through desktop audit

Should the DAP identify an area of concern, the diagnostic service may be subject to a mid-cycle on-site assessment by a DAP accreditation officer.

The accreditation award

The Diagnostic Accreditation Program of BC is the only regulatory body that can grant the accreditation award on behalf of its governing authority.

Accreditation awards possible are:

1. **Full accreditation** for a period of four years.
2. **Accreditation with report:** This award will be granted to an organization that delivers clinically safe and reliable services but has some anomalies to correct in its organization before it can be granted full accreditation status. The time frame in which the report must be provided to the DAP will form part of the award requirements.
3. **Non-accreditation:** This status will be given to an organization that does not meet the basic requirement of a clinically safe and reliable service. Non-accreditation status means that no physician in BC may practise in, nor refer patients to, a non-accredited facility. Under current government policy, the Medical Services Plan will also withdraw billing approvals.

As a condition of accreditation, facilities must prominently display the original certificate of accreditation as issued by the DAP. This indicates to the public and patients attending the facility that clinically safe and reliable services are provided by the facility.

Quality framework

All accreditation programs of the Diagnostic Accreditation Program are based upon a quality framework and continuous quality improvement principles. For the purposes of its accreditation programs, the following definitions for quality and quality improvement have been adopted by the Diagnostic Accreditation Program.

Quality

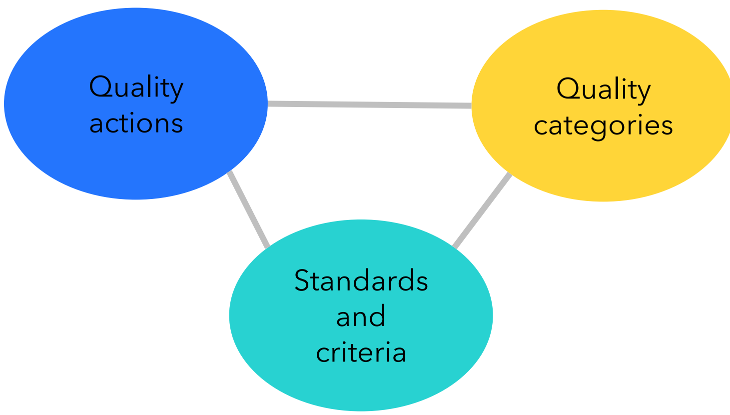
The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality improvement

A process that seeks to meet client's needs and expectations by using a structured approach to selectively identify areas to improve, and that improves all aspect of the services, including outcomes of service to patients and clients.

Quality framework

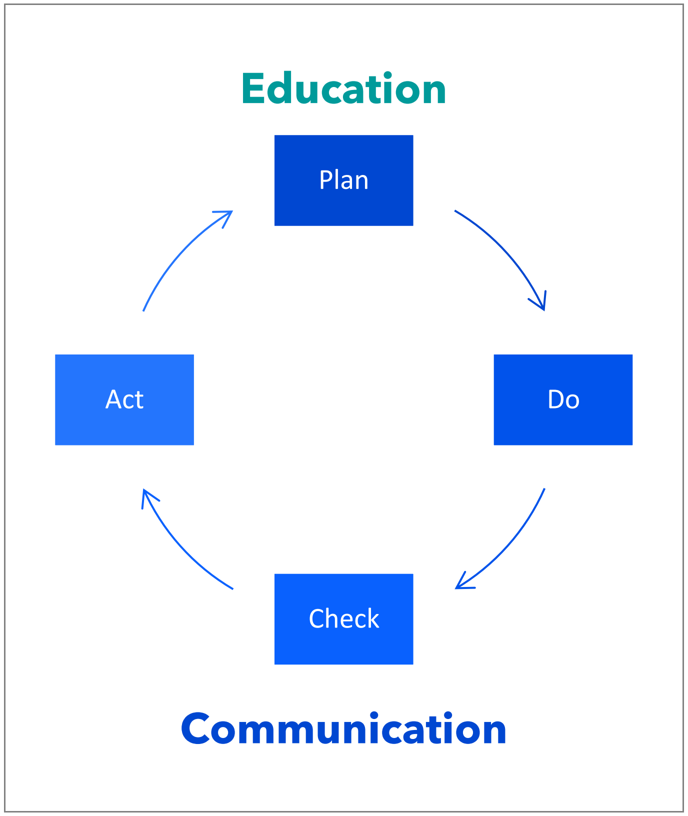
The Diagnostic Accreditation Program has adopted a quality framework that consists of quality actions and quality categories. The quality actions are those activities related to the Shewart Cycle (Plan-Do-Check-Act) and to supporting processes of education and communication. The quality categories are groups of specific activities that define mandatory requirements and best practices. This framework is used as the basis for establishing standards and criteria that define the conditions for quality.



- Standards and criteria are used to define the conditions for quality
- All standards and criteria are linked to a quality action and category

Quality actions

The quality actions are based upon the Shewart cycle that provides an evidence-based approach to continuous improvement. The Shewart cycle is most commonly referred to as the Plan-Do-Check-Act (PDCA) cycle of activities. Augmenting this cycle are the activities of education and communication.



Plan	Involves those activities related to assessing, identifying, analyzing, problem solving, prioritizing and defining.
Do	Involves those activities related to implementation or putting into effect.
Check	Involves those activities that evaluate, monitor, control or check.
Act	Involves those activities related to taking corrective action when an unanticipated outcome becomes apparent through the "check" activities.
Education	Involves those activities related to providing and developing knowledge in others.
Communication	Involves those activities related to imparting information and obtaining information from others.

Accreditation standards

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

Standards

- Outcome focused
- Directed at the operational level
- Goal statements of best practice
- Directive not prescriptive

Criteria and criterion descriptors

- Specify activities to be completed
- Roll up standard attainment

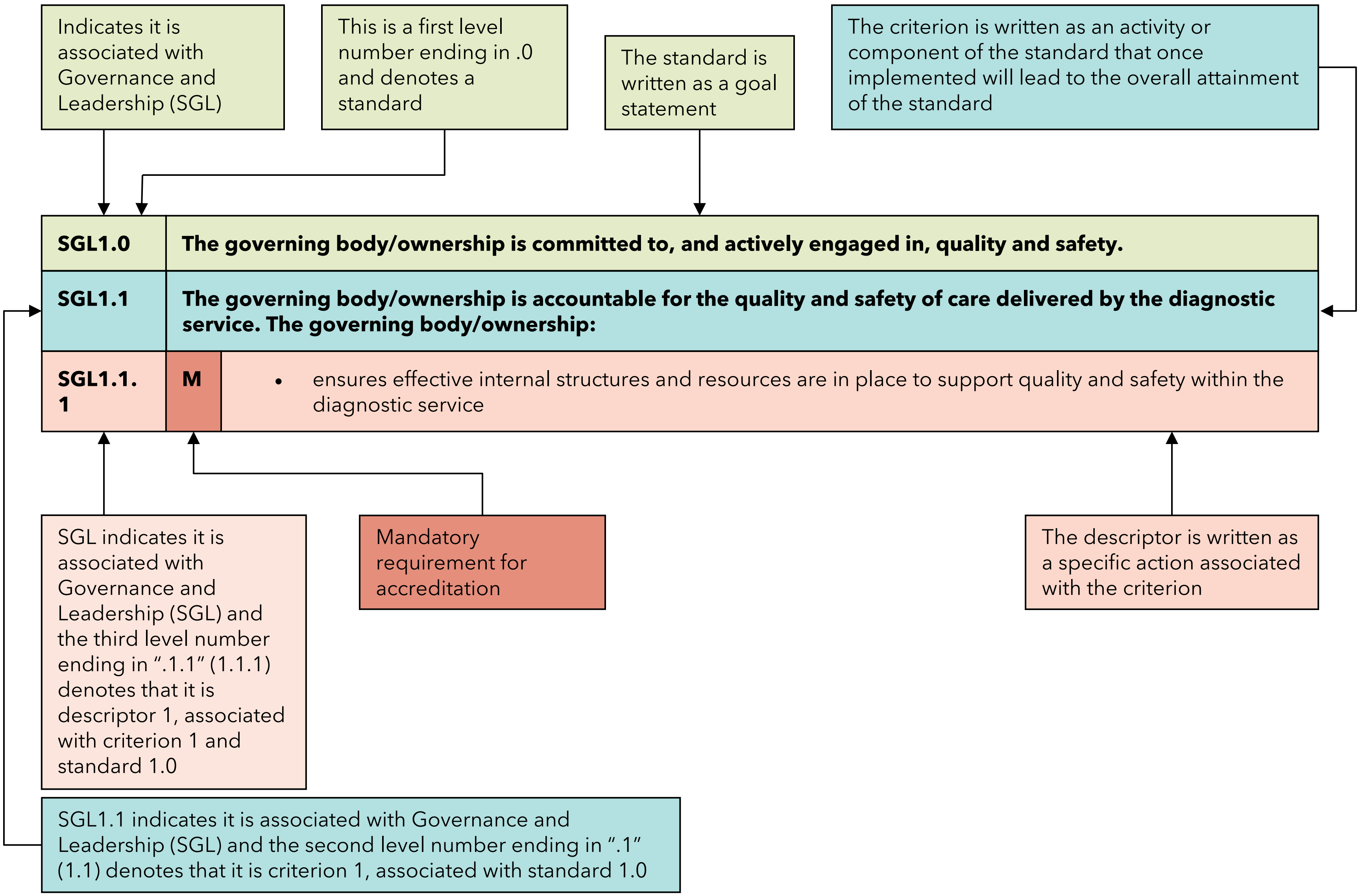
The Diagnostic Accreditation Program's accreditation standards are developed through a collaborative, consultative and consensus building process that involves health professionals and organizations, academics, experts, consumers, health authorities, colleges and the Ministry of Health. The process for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

The DAP accreditation standards consist of three components:

1. **Standard** – A goal statement of achievable levels of performance. An accreditation standard is identified by a first level whole number ending in ".0" such as 1.0, 2.0, 3.0 etc.
2. **Criterion** – Activities or components of the standards that once implemented lead to the overall attainment of the standard. A criterion is identified by the first level number indicating the standard that it is associated to, and a second level number such as X.1, X.2, X.3, etc.
3. **Criterion descriptors** – Specific actions for each criterion. Criterion descriptors are identified by the first level standards number, the second level criterion number and a third level criterion number such as X.Y.1, X.Y.2, etc. A criterion

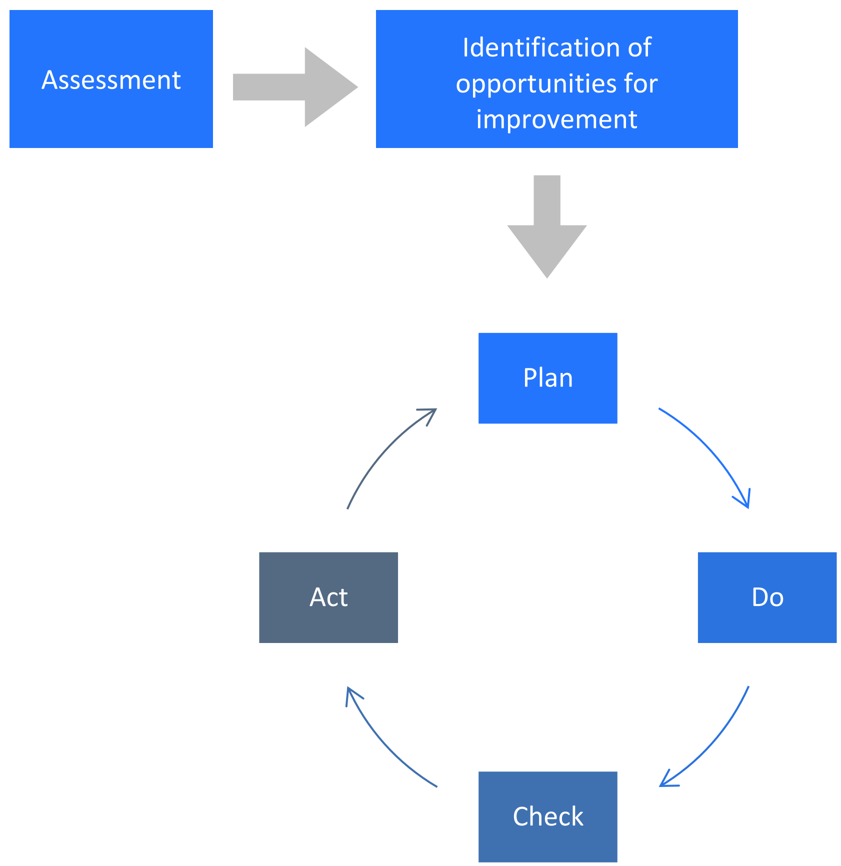
descriptor is either a mandatory requirement for accreditation, or a best practice. Mandatory criterion descriptors are indicated by a bold type face **M**.

Example of an accreditation standard



Self-assessment and on-site assessment information

Conducting a self-assessment enables the diagnostic service to take a snapshot of how they currently measure up relative to stated accreditation standards. Assessing the diagnostic service's practices provides a profile of the strengths, risks and opportunities for improvement. This is both a valuable process and tool to enable the management to focus continuous quality improvement efforts toward specific activities and take action with the creation of a quality improvement plan.



Self-assessment

During the self-assessment process, the diagnostic service assesses itself relative to stated standards, criteria and criterion descriptors by using a rating scale. Ideally, the individuals who are involved in this process are those who are able to comment on practices that happen on a day-to-day basis and those who have operational responsibility. In most diagnostic services, this process will involve directors, managers, department heads, chief technologists, supervisors, technologists, and physicians. The self-assessment may be completed by a team, or by an individual who consults or meets with others. It is at the discretion of the diagnostic service to determine who will be involved in conducting the self-assessment and completing the self-assessment documentation.

The rating scale

A rating scale has been developed to allow diagnostic services to assess how well accreditation criteria are fulfilled. The scale points represent five performance categories and a “not applicable” option. The following rating scale guide allows for performance to be assessed relative to the accreditation criteria.

5	Exceptional Performance ☐ All criterion descriptors have been fulfilled AND There is/are ☐ Awareness by all relevant staff ☐ Processes to ensure intended outcomes are achieved [checking/evaluating/auditing/monitoring] ☐ Corrective actions undertaken as needed ☐ Continuous improvement efforts ☐ Evidence* to support the above
4	☐ All criterion descriptors have been fulfilled ☐ There is evidence* to support the above
3	☐ Partial or full implementation of criterion descriptors
2	There is ☐ Recognition of need to implement criterion ☐ Engagement in planning activities to address criterion ——— ☐ Partial or full implementation, with concerns identified by surveyors Examples a) issues related to safety b) less than desirable results may be achieved c) staff are not aware of critical practices and procedures
1	☐ Criterion applicable but no action undertaken
	*Evidence may take many possible forms

On-site assessment

The on-site assessment is conducted by DAP accreditation officer(s). During the on-site assessment, the performance of the diagnostic service relative to each standard and criteria will be assessed. Collection of assessment data will be through discussions with the diagnostic service management and staff, reviewing documentation and observing the diagnostic processes. The on-site assessment also permits the exchange of knowledge and best practices between the diagnostic service and the DAP accreditation officer(s).

DAP accreditation officer(s) follow specific assessment protocols that directs their assessment activities and allows for comments, observations and recommendations to be recorded. DAP accreditation officer(s) assess and use the same rating scale as the diagnostic service to determine how well accreditation criteria have been fulfilled.

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.

The governance and leadership section of the accreditation standards addresses:

- governance accountabilities
- leadership of the diagnostic service’s day to day operations
- diagnostic service planning
- values and ethics

Governance

No.	Description
SGL1.0	**THE GOVERNING BODY/OWNERSHIP IS COMMITTED TO, AND ACTIVELY ENGAGED IN, QUALITY AND SAFETY.**
SGL1.1	**The governing body/ownership is accountable for the quality and safety of care delivered by the diagnostic service.** *Intent: The governing body/ownership defines their expectations for the diagnostic service management and senior leaders to create and maintain a quality and safety focused culture.*
SGL1.1.1	**M** The governing body/ownership ensures effective internal structures and resources are in place to support quality and safety within the diagnostic service.
SGL1.1.2	**M** Reports on the quality and safety within the diagnostic service are received by the governing body/ownership at least once per year.

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.*
SGL2.1	**Accountability and responsibility is assigned for:**
SGL2.1.1	• defining scope of service
SGL2.1.2	• budget development
SGL2.1.3	• medical staff
SGL2.1.4	• human resources
SGL2.1.5	• satisfaction/complaints management
SGL2.1.6	• staff safety
SGL2.1.7	• patient safety
SGL2.1.8	• infection prevention and control

No.		Description
SGL2.1.9		• disaster planning
SGL2.1.10		• quality improvement
SGL2.1.11		• information management
SGL2.1.12		• equipment and supplies
SGL2.1.13		• technical operations
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.*
SGL2.2.4	**M**	There is a defined structure and process through which the medical, administrative and technical leaders are held accountable.
SGL2.2.5	**M**	Medical, administrative and technical leaders work collaboratively to provide effective oversight of diagnostic service quality and safety. *Guidance: Reported safety and quality issues are discussed regularly.*
SGL2.2.6		The organization provides leaders with the necessary training and support to effectively oversee the diagnostic service quality and safety.
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).

Service planning

No.	Description
SGL3.0	**DIAGNOSTIC SERVICES MEET THE CURRENT AND FUTURE NEEDS OF THE PATIENT POPULATION IT SERVES.**
SGL3.1	**The diagnostic service is in alignment with the mission, vision, values and strategic direction of the organization.** *Intent: The governing body/ownership establishes the direction and unity of purpose for the organization.*
SGL3.1.1	The mission, vision, and values of the organization have been communicated to all staff.
SGL3.1.2	The strategic direction of the organization is in alignment with the mission, vision and values.
SGL3.1.3	The strategic direction of the organization has been communicated to the diagnostic service leadership.
SGL3.2	**The diagnostic service defines and documents their scope of services.**
SGL3.2.1	The diagnostic service determines the scope of services using a process that considers relevant factors (e.g. patient population, existing capacity, clinical value of testing, referring physician requirements, etc.).
SGL3.2.2	The scope of service is documented and communicated to all staff.
SGL3.2.3	The scope of service is communicated to referring practitioners.
SGL3.3	**Annual operating and capital budgets are developed.**
SGL3.3.1	Resources required to deliver the scope of service are identified.
SGL3.3.2	New capital equipment required to deliver the scope of service is identified.
SGL3.3.3	Budgets are developed with input from key leaders.

Ethics

No.	Description
SGL4.0	**THE DIAGNOSTIC SERVICE DELIVERS SERVICES AND MAKES DECISIONS IN ACCORDANCE WITH ETHICAL PRINCIPLES.**
SGL4.1	**The diagnostic service promotes an environment that fosters and requires ethical and legal behaviour.**
SGL4.1.1	There is a written code of ethics for professional behaviour.
SGL4.1.2	There is a process for addressing unethical or illegal behaviour.

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.

The medical staff section of the accreditation standards addresses:

- medical staff leadership
- medical staff credentialing
- delegation of medical acts
- medical staff contracts/agreements

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:
SMS1.1.1	**M**	• works in collaboration with the governing body/ownership to grant physician privileges within the diagnostic service
SMS1.1.2		• establishes standardized interpretive comments and report formats
SMS1.1.3	**M**	• is involved in the development and monitoring of performance measures for the diagnostic service *Guidance: Medical leader involvement is critical to the development of clinical performance measures/indicators for the diagnostic service.*
SMS1.1.4		• makes recommendation on the number of qualified competent medical staff necessary to ensure quality and safety of diagnostic service provision
SMS1.1.5	**M**	• establishes and monitors policies and procedures for the delegation of medical acts
SMS1.1.6	**M**	• authorizes the implementation of technical/medical operational policies and procedures related to the diagnostic service
SMS1.1.7		• coordinates and integrates the diagnostic service with other departments and services *Intent: If additional testing is recommended for a patient, the facility should have the capacity to perform the recommended tests, or refer the patient to another facility.*
SMS1.1.8	**M**	• continuously monitors the professional performance of medical staff practising in the diagnostic service through a peer review process
SMS1.1.9	**M**	• actively participates in quality oversight and improvement activities

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.**

No.		Description
SMS1.2.1	**M**	The medical leader visits the facility prior to assuming responsibility for medical leadership for a new service.
SMS1.2.2	**M**	At a minimum, the medical leader visits the facility annually. *Guidance: The annual visit may be undertaken by a delegated physician, or a technical delegate deemed qualified by the medical leader unless delegated medical acts are performed on-site.*
SMS1.2.3	**M**	The medical leader or delegate assesses the complexity of services provided and undertakes more frequent visits if warranted.
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.
SMS1.3.3	**M**	In the event that a delegate conducts the visit, the medical leader must receive a copy of the log within two weeks of visit completion.
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
SMS3.3.4	**M** • the date of the assessment

No.	Description	
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.

Medical staff contracts/agreements

Introduction

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

No.	Description
SMS4.0	**THE DIAGNOSTIC SERVICE EFFECTIVELY MANAGES RELATIONSHIPS WITH MEDICAL PRACTITIONERS UNDER CONTRACT/AGREEMENT.**
SMS4.1	**There is a contract/agreement in place between the medical practitioner/group and the diagnostic service that specifies:**
SMS4.1.1	• services to be provided
SMS4.1.2	• names of the medical practitioner(s) providing the services
SMS4.1.3	• hours of service provision by the medical practitioner(s)
SMS4.1.4	• location of where the medical practitioner(s) will be providing service
SMS4.1.5	• provision for on-call service during and outside regular operating hours

No.	Description		
SMS4.1.6	**M**	•	participation in quality improvement activities[1]
SMS4.1.7		•	compliance with occupational health and safety regulations
SMS4.1.8		•	compliance with organizational and service policies and procedures
SMS4.2	**There is a designated individual(s) assigned to manage the contract between the medical practitioner/group and the diagnostic service to:**		
SMS4.2.1		•	ensure an effective and quality service is provided
SMS4.2.2		•	document any changes to the contract
SMS4.2.3		•	resolve any concerns brought forward by either party

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.

The human resources section of the accreditation standards addresses:

- human resources planning
- staff selection and retention
- staff roles and records
- staff orientation and training
- professional development and continuing education
- clinical teaching
- competency assessment
- performance feedback

Human resources planning

No.	Description
SHR1.0	**THE DIAGNOSTIC SERVICE IDENTIFIES CURRENT AND FUTURE HUMAN RESOURCE REQUIREMENTS.**
SHR1.1	**Human resource planning supports the diagnostic service's goals and objectives.**

No.		Description
SHR1.1.1		There is a human resources plan to identify adequate staffing numbers and required competencies to meet the current and future needs of the diagnostic service.
SHR1.1.2		The human resources planning process involves key staff who are knowledgeable about the required competencies of staff, diagnostic technology and service delivery.
SHR1.1.3		Clinical teaching requirements are included in the human resources plan. *Intent: Human resource planning including the allocation of resources for both staff and student education.*
SHR1.1.4		The human resources plan is monitored and revised as necessary.

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).
SHR2.2		**The diagnostic service is able to retain and engage staff.**
SHR2.2.1		The diagnostic service has strategies in place to retain qualified staff.
SHR2.2.2		There are mechanisms in place to assess and enhance workforce engagement, motivation and morale (e.g. involvement in appropriate decision-making, staff-surveys).
SHR2.2.3		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.

No.		Description
SHR2.2.4		Workloads are monitored and managed.

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.
SHR3.1.2		Job descriptions are regularly reviewed.
SHR3.1.3		Staff are aware of their responsibilities and understand reporting relationships.
SHR4.0		**STAFF RECORDS ARE COMPLETE, CURRENT AND CONFIDENTIAL.**
SHR4.1		**Individual human resource records are kept for all staff and contain:**
SHR4.1.1		• evidence of qualifications including certification or registration
SHR4.1.2		• evidence of education and training appropriate for the position
SHR4.1.3		• immunization and health reports as required by the organization's human resources policies
SHR4.1.4		• orientation, continuing education and in-service training records
SHR4.1.5		• performance evaluations and feedback
SHR4.1.6		• competency assessments
SHR4.1.7		• recruitment information including references
SHR4.1.8		• evidence of a criminal record check if in contact with children or vulnerable adults
SHR4.2		**Human resource information and records are kept confidential.**
SHR4.2.1	**M**	Only authorized individuals have access to records.
SHR4.2.2	**M**	Consent is obtained from the employee prior to the release of information contained in their human resources 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. release) is limited to authorized individuals within the organization.*

No.		Description
SHR4.2.3	**M**	Records are disposed of appropriately and in accordance with legislation.

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
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
SHR5.1.16		• patient rights and patient consent

No.		Description
SHR5.1.17		• the organization's mission, vision and values
SHR5.1.18		• sensitivity to cultural and religious diversity
SHR5.2		**Orientation and ongoing training is provided to existing staff to uphold the quality and safety of the diagnostic service.**
SHR5.2.1	**M**	Orientation and training is provided to current staff in response to changing roles, technology, competency demands, laws and regulations or after an extended absence.
		Existing staff are provided with ongoing training or orientation in:
SHR5.2.2	**M**	• infection prevention and control (e.g. blood and body fluid exposure procedures)
SHR5.2.3	**M**	• identifying, reporting and disclosing information regarding adverse events and critical incidents
SHR5.2.4	**M**	• instrument and equipment use, maintenance and safety
SHR5.2.5	**M**	• patient identification
SHR5.2.6	**M**	• ensuring the confidentiality of data and information • *Guidance: This includes information on the release of patient information, legal responsibilities regarding confidentiality, the possible consequences of breeching confidentiality, and reporting, documenting and investigating security incidents.*
SHR5.2.7		• risk management
SHR5.2.8		• quality improvement methods and tools for those involved in improvement initiatives

Professional development and continuing education

No.	Description
SHR5.3	**Professional development and continuing education are available for staff.**
SHR5.3.1	Professional development and continuing education is encouraged and supported.
SHR5.3.2	Staff participate in ongoing education, training and professional development to meet the needs of the diagnostic service.
SHR5.3.3	The diagnostic service monitors education and training to determine if objectives have been achieved and to identify improvements.
SHR5.3.4	The diagnostic service ensures that opportunities for reinforcement of knowledge and retraining are made available.

Clinical teaching

No.	Description	
SHR5.4	**Participation in clinical teaching does not compromise patient care.**	
SHR5.4.1	**M**	Patient care is not compromised during or as a result of clinical teaching. *Intent: The diagnostic service has determined if, when and under what conditions students can work alone or unsupervised, and what safeguards are in place.*
SHR5.4.2		Service standards of the diagnostic service are maintained during clinical teaching.
SHR5.4.3		Staff assigned to clinical teaching understand their roles and responsibilities and have the appropriate qualifications as specified by the academic institution.
SHR5.4.4		Students are supervised by experienced and qualified staff.

Competency assessment

No.	Description	
SHR6.0	**THE DIAGNOSTIC SERVICE HAS A STAFF PERFORMANCE MANAGEMENT SYSTEM TO IMPROVE THE QUALITY OF SERVICE.**	
SHR6.1	**The competency of individual staff is assessed.**	
SHR6.1.1	**M**	Competency assessment evaluates the knowledge, skills and abilities of the staff.
SHR6.1.2	**M**	Competency assessment of new staff is performed prior to the completion of a probationary or orientation period.
SHR6.1.3	**M**	Competency assessment of existing staff is performed when new technology or new procedures are introduced.
SHR6.1.4	**M**	Existing staff members are assessed on the use of current technology or current procedures prior to performance appraisals.
SHR6.1.5	**M**	Competency assessments are conducted and reviewed by individuals with appropriate education, experience and qualifications.
SHR6.1.6	**M**	Action is taken when a staff member's assessed competence does not meet expectations or when the staff member is not performing satisfactorily.

Performance feedback

No.	Description	
SHR6.2	**Individual staff members receive performance feedback.**	
SHR6.2.1	**M**	A performance appraisal is regularly conducted based on job responsibilities and expectations. *Guidance: Performance appraisals are conducted at a frequency determined by the service. The service is strongly encouraged to conduct appraisals every 1-2 years.*
SHR6.2.2		Development plans are generated, monitored and revised, as necessary.

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.

The patient and client focus section of the accreditation standards addresses:

- management of patient and client relationships
- measurement of patient and client satisfaction
- patient rights and consent

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.**
SPC1.1		**The diagnostic service identifies its patients and clients and establishes plans to meet their needs.**
SPC1.1.1		The diagnostic service identifies patients and clients and defines their needs.
SPC1.1.2		The goals and objectives of the diagnostic service are aligned with patient and client needs and expectations.
SPC1.1.3		Cultural and spiritual sensitivities of patients and clients are acknowledged and respected without compromising quality or safety.
SPC1.2		**Service standards of the diagnostic service are defined and communicated to patients and clients.**
SPC1.2.1	**M**	The time from referral to the test is defined and monitored.
SPC1.2.2	**M**	There is a process for patient prioritization.

No.		Description
SPC1.2.3	**M**	Turnaround times for reports are defined. *Guidance: Turnaround times are established for all aspects of the reporting process including testing completion, dictation, transcription and distribution of the final report.*
SPC1.2.4		Service standards, including turnaround times, are made available to referring practitioners.
SPC1.3		**Interpreting physicians are responsive to patient-related clinician inquiries.**
SPC1.3.1		Interpreting physicians are responsive to case specific or procedural inquiries.
SPC1.3.2		Interpreting physicians provide education to clinicians in a timely and meaningful manner when needed.

Measurement of patient and client satisfaction

No.		Description
SPC2.0		**PATIENT AND CLIENT SATISFACTION IS MEASURED TO GAIN INFORMATION FOR IMPROVEMENT.**
SPC2.1		**The diagnostic service collects and analyzes patient and client satisfaction data to improve service delivery.**
SPC2.1.1		Data collection methods are appropriate for each patient and client group.
SPC2.1.2		Data collection methods allow information to be associated to specific processes within the diagnostic service.
SPC2.1.3		Data collection methods ensure comparable results from one cycle to the next.
SPC2.1.4		Patient and client satisfaction data is analyzed.
SPC2.1.5		Goals and priorities for improvement are determined.
SPC2.2		**There is a process in place to gather and follow-up on patient and client complaints.**
SPC2.2.1		Patients and clients are informed of the process to register complaints and feedback.
SPC2.2.2		There are methods to identify complaints within the patient and client satisfaction data that require specific action.
SPC2.2.3		There is a procedure for documenting complaints from patients and clients.
SPC2.2.4	**M**	Responses to patient and client inquiries and complaints are addressed promptly and effectively.
SPC2.2.5		The resolution of complaints is documented.
SPC2.2.6		Information gained from complaints is used to make improvements as necessary.

Patient rights and consent

No.	Description
SPC3.0	**THE DIAGNOSTIC SERVICE RESPECTS THE RIGHTS OF PATIENTS.** *Refer to the Government of Canada's Patient's Bill of Rights for additional information, accessible at* http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/BP/prb0131-e.htm.
SPC3.1	**Patient rights are communicated to patients and staff.**
SPC3.1.1	Patients are aware of their rights.
SPC3.1.2	Staff are aware of patient rights.
SPC3.2	**Patients are involved in decision-making about their care, procedure(s) and/or service(s).** *Intent: Prior to performing a test, patients are involved in the decision-making process and are provided with sufficient information regarding the procedure to make an informed decision.*
SPC3.2.1	Patients are provided with information about their procedures so that they can participate in making informed decisions.
SPC3.2.2	Patients are provided with information about their right to refuse a procedure, or service.
SPC3.2.3	The patient is made aware of the health-care professionals responsible for their care, procedures or services.
SPC3.2.4	When patients are unable to make decisions about their procedure a substitute decision maker(s) is involved in making these decisions in accordance with policy and provincial law and regulation.
SPC3.2.5	**M** Decisions made by a patient with regard to giving or withholding consent is respected.

General safety

This section of the accreditation standards addresses:

- key management responsibilities and activities as outlined in occupational health and safety regulations
- safety practices and equipment
- the physical environment of the diagnostic service
- preparing for disasters and emergencies

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.*
SSA1.1.3	**M**	• reviewing health and safety activities and incident trends
SSA1.1.4	**M**	• identifying and implementing the action(s) to resolve health and safety concerns

No.		Description
SSA1.1.5	**M**	• the prompt investigation of staff related safety incidents including near misses to determine action necessary to prevent recurrence *Intent: A **near miss** is an incident that did not result in injury, illness or damage but had the potential to do so.*
SSA1.1.6	**M**	• the retention of records and statistics, including reports of safety inspections and staff incident investigations
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.*
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.**	

No.		Description
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.*
SSA1.3.2	**M**	Minutes of the last three safety committee meetings are posted.

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.
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.*
SSA1.4.7	**M**	Chemicals are disposed of in accordance with WHMIS requirements.
SSA1.5		**Spills are handled effectively and safely.** *Guidance: Based upon the chemicals and volumes used, the diagnostic service should consult with WorkSafeBC to determine if spill kits and/or spill control teams are required.*
SSA1.5.1	**M**	Spill kits are readily available.
SSA1.5.2	**M**	Procedures to control and clean-up spills are documented and readily available to staff.
SSA1.6		**Fire safety measures are implemented.**

No.		Description
SSA1.6.1	**M**	Appropriate fire extinguishing equipment and procedures are in place.
SSA1.6.2	**M**	Fire drills are conducted at least once per year.
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).
SSA1.7.2	**M**	Regular inspections are performed to assess electrical safety (e.g. extension cords and surge power bars are assessed for damage and inappropriate use, proper isolation of electrical equipment attached to the patient, etc.).
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**	Workplace 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.*
SSA1.9.2		There are resources available to educate staff on proper body mechanics and equipment adjustments.
SSA1.9.3		Positioning and immobilizing devices are available to staff.
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.
SSA1.10	**Compressed gas is maintained and stored safely.** *Guidance: An example of a compressed gas would be oxygen.*	
SSA1.10.1	**M**	Gas cylinders are clearly labeled with the cylinder's contents.
SSA1.10.2	**M**	A pressure-reducing regulator or device is used for all compressed gas cylinders.
SSA1.10.3	**M**	Any gauge whose pointer does not go back to the zero point when pressure is removed is replaced.
SSA1.10.4	**M**	Adapters between cylinders and pressure reducing regulators are not used.
SSA1.10.5	**M**	Cylinders not in use are shut off and capped.

No.		Description
SSA1.10.6	**M**	Cylinders are secured by a holder or device specifically designed device and are protected from sources of damage (e.g. overhead hazards, high temperatures).
SSA1.10.7	**M**	Cylinder carts are used to move large cylinders and specifically designed cylinder holders are used to carry small cylinders.

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.**
SSA2.1.1		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.*
SSA2.1.2	**M**	Emergency exit routes are marked and provide an unimpeded exit.
SSA2.2		**The location of the diagnostic service is accessible to the patient population it serves.**
SSA2.2.1		Clear signage is in place to direct patients to the diagnostic service.
SSA2.2.2		Patients with special needs can access the location with ease.
SSA2.2.3		Patient washrooms are clean, conveniently located and accessible.
SSA2.3		**The physical environment ensures patient safety and privacy.**
SSA2.3.1	**M**	Patient areas are safe and clean.
SSA2.3.2	**M**	A secure and private location for changing clothing and for the temporary storage of personal items is available.
SSA2.3.3	**M**	Furniture is safe for patient use.
SSA2.3.4		Confidential or sensitive information is collected from and communicated to patients in an area that does not compromise their privacy. *Guidance: This includes telephone consultations that involve the exchange of patient information.*
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.

No.		Description
SSA2.4		**The design and layout of the space supports safe and appropriate service delivery.**
SSA2.4.1		For each activity undertaken within the diagnostic service, there are appropriate furnishings, work surfaces and floor finishes.
SSA2.4.2		There is sufficient space to allow unobstructed movement and safe working conditions within the diagnostic service and around large pieces of equipment.
SSA2.4.3	**M**	Security measures are in place to prevent theft and tampering of equipment, drugs, chemicals and confidential information. *Guidance: The threat of theft or tampering is assessed, and based upon that assessment appropriate security measures are implemented.*
SSA2.5		**The physical environment meets the needs of staff.**
SSA2.5.1	**M**	A secure and private location for changing clothing and for storage of personal belongings is available to staff.
SSA2.5.2		A separate and comfortable location to rest is available to staff during break times.
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.*
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).
SSA2.6.3		Access to hand washing sinks is unimpeded. *Guidance: If there is only one sink available and that sink may also be used for other than hand washing there is a process to clean the sink prior to using the sink for hand washing; or a sanitizing gel must be made available to staff to use followed by hand washing at the nearest available clean sink. Unimpeded access means that staff would always be able to access the sink (e.g. a sink located in a washroom is not considered as having unimpeded access).*
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.

No.		Description
SSA2.7.2	**M**	Emergency lighting is available in the event of power failure. *Guidance: Emergency lighting units must be tested regularly.*
SSA2.7.3		Ambient temperature, humidity, lighting, noise level and air quality is controlled to a level compatible with staff and patient comfort and that does not compromise diagnostic procedures. *Guidance: Temperature and humidity concerns are addressed in the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) publication Handbook of Fundamentals or in the WorkSafeBC publication Indoor Air Quality that may be accessed from the website* www.worksafebc.com/publications/health_and_safety/by_topic/assets/pdf/indoor_air_bk89.pdf.
SSA2.7.4		Air flow is monitored to ensure adequate ventilation, as required. *Guidance: The monitoring of air flow (e.g. the number of air exchanges per hour) may be a responsibility of the facility management and may not necessarily be conducted by the diagnostic service.*

Disaster and emergency preparedness

Introduction

Disaster and emergency preparedness examines how the diagnostic service plans to respond to disasters. A disaster may be internal such as a flood, fire, or loss of electrical power; or the disaster may be a community-wide disaster such as an earthquake.

No.	Description
SSA3.0	**THE DIAGNOSTIC SERVICE IS PREPARED FOR DISASTERS AND EMERGENCIES.**
SSA3.1	**There is a disaster and emergency preparedness plan that addresses a response to an emergency.**
SSA3.1.1	The role and capability of the diagnostic service during a disaster or emergency is identified.
	The plan for response to disasters and emergencies includes:
SSA3.1.2	• a staff recall system
SSA3.1.3	• access to first aid equipment
SSA3.1.4	• alternate service sites if needed
SSA3.1.5	• alternate sources of supplies, utilities and communication
SSA3.2	**The disaster and emergency response plan is regularly reviewed to ensure it is valid and updated.**

No.	Description
SSA3.2.1	Disaster and emergency plans are reviewed with all staff and they are aware of their roles and responsibilities in the event the plan is implemented.
SSA3.2.2	The plan is tested through practice drills. Changes to plans, procedures and training methods are made when necessary.
SSA3.2.3	Contact names and phone numbers on fan-out lists are current.

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.

The patient safety section of the accreditation standards addresses:

- creating a culture of patient safety
- patient identification
- medication management and administration
- risk and disclosure
- medical emergencies

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.**
SPS1.1	**The diagnostic service demonstrates that patient safety is a core priority.**
SPS1.1.1	A patient safety program is implemented involving the staff of the diagnostic service.
SPS1.1.2	The patient safety program is reviewed on a regular basis and new information is incorporated when appropriate.
SPS1.1.3	Staff are aware of and are able to demonstrate their responsibilities relative to patient safety.
SPS1.1.4	Patient safety targets are established by the diagnostic service and performance is reviewed and reported on regularly.
SPS1.1.5	Patient safety data is reviewed and used to improve patient safety.
SPS1.2	**The activities of the diagnostic service ensure patient safety.**

No.		Description
SPS1.2.1		Mechanisms are available for staff to identify, provide feedback on, and communicate openly about patient safety issues and concerns.
SPS1.2.2	**M**	There is a process for patients and their advocates to report concerns related to patient safety.
SPS1.2.3	**M**	There are systems in place to ensure that patient safety notices, alerts and other information is communicated.
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).*
SPS1.2.5	**M**	All patient safety issues are documented and investigated.

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.**
SPS2.1.1	**M**	Patients are involved in the identification process to the fullest extent possible.
SPS2.1.2	**M**	Patient identification is confirmed prior to testing by the person(s) performing the test.
SPS2.1.3	**M**	At least two unique patient identifiers are used when verifying patient identification.
SPS2.1.4	**M**	In-patients are identified with a wristband or service-approved alternative procedure.
SPS2.1.5	**M**	Staff confirm the information on the wristband is consistent with verbal information provided by the patient.
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.
SPS2.2		**There are methods in place to address situations where the identity of the patient is unknown.**
SPS2.2.1	**M**	An emergency identification method is used when the patient's identity is unknown. *Guidance: This may contain an alias name and a unique ID number such as a medical record number.*
SPS2.2.2	**M**	The temporary patient identification is attached to the patient, and affixed on patient tracings, as applicable.

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

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.
SPS3.1.3	**M** The diagnostic service regularly inspects all medication storage areas and medications.
SPS3.1.4	**M** All medications are disposed of using appropriate disposal methods.
SPS3.2	**The diagnostic service ensures that all medications are labeled.**
SPS3.2.1	**M** Medication containers are labeled with the medication name, strength and quantity when medications are prepared but not administered immediately.
SPS3.2.2	**M** All medications are labeled with the date prepared.
SPS3.2.3	**M** Medications are labeled with an expiration date and when not administered within 24 hours, or when the expiration occurs in less than 24 hours.
SPS3.2.4	**M** Any unlabeled medication containers are discarded immediately.
SPS3.3	**The appropriateness of all medication orders is reviewed.**
SPS3.3.1	**M** Only authorized staff request medications. *Guidance: There is a facility policy that defines "authorized individual" that includes medical physicians and other designated health professionals as permitted by governing legislation, rules and bylaws.*
SPS3.3.2	**M** Medication orders are reviewed for possible patient allergies or sensitivities.
SPS3.3.3	**M** Medication orders are reviewed for the appropriateness of the dose, frequency, and route of administration.
SPS3.3.4	**M** Medication orders are reviewed for potential contraindications and adverse interactions.

No.	Description
SPS3.3.5	**M** All concerns, issues, or questions related to the appropriateness of a medication order are resolved with the prescriber or staff involved with the patient's care or services prior to administration.
SPS3.4	**Medications are administered safely.**
SPS3.4.1	**M** Only medical practitioners and authorized staff obtain and administer medication.
SPS3.4.2	**M** Patient identity is verified prior to medication administration.
SPS3.4.3	**M** There is a process in place to ensure that the correct medication is selected prior to administration.
SPS3.4.4	**M** Prior to administration, the medication is visually inspected for colour, clarity and expiration date.
SPS3.4.5	**M** There is a process in place to ensure the individual administering the medication verifies that the medication is administered at the proper time, in the prescribed dose, and by the correct route to the correct patient.
SPS3.5	**Patients are monitored to ensure that medication(s) have been administered safely and effectively.**
SPS3.5.1	**M** Patients are monitored to assess the effectiveness of the medication(s) administered to them.
SPS3.5.2	**M** Patients are monitored for any potential side effects or adverse reactions resulting from medication administration.
SPS3.5.3	**M** Staff know how to respond to adverse drug events, significant drug reactions, and medication errors.
SPS3.5.4	**M** Processes are in place to ensure the safety of patients prior to discharge or release from the diagnostic service after receiving medications. *Guidance: An example of this would be for patients who have been administered amild sedative for a procedure (e.g. Ativan). Prior to the patient being discharged, the diagnostic service should ensure that the patient has a safe way of getting home.*
SPS3.5.5	**M** Prior to discharge from the diagnostic service, the patient is monitored for a sufficient amount of time to ensure readiness for discharge.
SPS3.5.6	**M** Readiness to discharge is documented in the medical record.

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.**

No.		Description
SPS4.1.1		Definitions of adverse events, critical incidents and near misses applicable to the diagnostic service are communicated to all staff.
SPS4.1.2	**M**	Policies, procedures and practices for addressing adverse events and critical incidents are documented and available to all staff.
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.
SPS4.1.5		There is a systematic process to investigate adverse events and critical incidents to determine multiple underlying contributing factors. *Guidance: The investigation process is appropriate for the magnitude of the problem and risk to patient or staff safety.*
SPS4.1.6		There are policies, procedures and practices for disclosing information to patients following an adverse event and/or critical incident.
SPS4.1.7		Staff know whom to contact for advice or direction and are aware of their role during an adverse event or critical incident.
SPS4.1.8		There is a defined process for reporting an adverse event or critical incident to the administration of the organization and to outside organizations.
SPS4.1.9		Support and counseling are available to patients, their families and staff following an adverse event or critical incident.
SPS4.2	**There is a process to determine and manage the medical significance of adverse events and critical incidents.**	
SPS4.2.1	**M**	All reported adverse events and critical incidents are immediately assessed by appropriate technical and medical staff to determine medical significance.
SPS4.2.2	**M**	The referring practitioner is informed in cases of medical significance.
SPS4.2.3		Appropriate technical and medical staff assesses indications for halting further tests and authorizing resumption.
SPS4.2.4		Medical staff assess indications for withholding diagnostic reports and review already released reports for potential recall.
SPS4.3	**Recommendations following an adverse event or critical incident are implemented to decrease the likelihood of recurrence.**	
SPS4.3.1		There are mechanisms in place for management to regularly track and trend aggregate data collected through the reporting process.
SPS4.3.2	**M**	Changes made to the diagnostic service's systems and processes to prevent recurrence are documented.

No.		Description
SPS4.3.3		Recommendations and changes implemented are communicated to relevant staff.
SPS4.3.4		Changes implemented are continuously monitored and evaluated to ensure effectiveness.

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.
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.

This section of the infection and prevention and control accreditation standards addresses:

- planning
- routine practices
- additional precautions
- cleaning of surfaces and ancillary medical equipment

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).
SIPC1.1.2	**M**	Activities associated with increased risk of infection to staff, patients and visitors are identified and assessed.
SIPC1.1.3	**M**	Precautions used to eliminate or minimize the risk of infection are identified and defined.
SIPC1.1.4		Responsibility for infection prevention and control activities is assigned.
SIPC1.1.5		There is access to up-to-date infection prevention and control resources (e.g. infection control practitioners, expert consultant(s) and website(s).
SIPC1.1.6	**M**	All staff receives ongoing training in the applicable infection and prevention and control policies and procedures relevant to their position or job.
SIPC1.1.7		Infection control data is reviewed and analyzed and actions are taken when issues are identified.

No.		Description
SIPC1.1.8		Infection control data is reported to an appropriate authority.
SIPC1.1.9		There is a regular review of the infection prevention and control plan.

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.*
SIPC2.1.1	**M**	Hand hygiene is performed with plain soap and running water, or alcohol based hand rubs.
SIPC2.1.2	**M**	Hand hygiene is performed before and after direct contact with a patient.
SIPC2.1.3	**M**	Hand hygiene is performed before gloves are put on and immediately after removing gloves.
SIPC2.1.4	**M**	Hand hygiene is performed between clean and dirty procedures on the same patient.
SIPC2.1.5	**M**	Hand hygiene is performed before preparing or handling medications.
SIPC2.1.6	**M**	Hand hygiene is performed if the staff member's skin becomes visibly contaminated (e.g. after contact with blood or body fluids).
SIPC2.1.7	**M**	There are sufficient, readily accessible, designated hand hygiene sinks or other accessible forms of hand hygiene products.
SIPC2.1.8	**M**	Appropriate hand hygiene is performed when in contact with patients that have known or suspected infectious diseases.
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.*

No.	Description
SIPC3.1	**Personal protective equipment is used appropriately.**
SIPC3.1.1	**M** Personal protective equipment is used when there is potential contact or exposure to blood and body fluids.
SIPC3.1.2	**M** Personal protective equipment is changed between patients.
SIPC3.1.3	**M** Personal protective equipment is removed and disposed of properly or reprocessed according to manufacturer's recommendations.
SIPC3.2	**Gloves are worn by staff for protection against infection.** *Intent: Gloves are used as an additional measure, not as a substitute for appropriate hand hygiene. Gloves are not required for routine patient care activities.*
SIPC3.2.1	**M** Gloves are worn when there is potential for contact with blood or body fluids.
SIPC3.2.2	**M** Gloves are worn when the staff member has open skin lesions on their hands.
SIPC3.2.3	**M** Gloves are changed between patients and procedures and disposed of properly.
SIPC3.2.4	**M** Gloves are removed immediately after a specific task and before touching clean environmental surfaces.
SIPC3.2.5	**M** Sterile gloves are worn for sterile procedures.
SIPC3.2.6	**M** Single-use disposable gloves are not reused or washed.
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.*
SIPC3.3.2	**M** Fit testing of N95 respirators/masks is performed annually and is documented. *Intent: A respirator/mask will not be effective unless it forms an adequate seal against the staff members face. The only way to be certain a specific respirator/mask forms this seal is to do a fit test.*

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).*
SIPC4.1.1	**M**	Patients with known or potential communicable diseases are identified. *Guidance: Known or suspected communicable diseases may be identified in many ways e.g. asking the patient, notation on the requisition, or noted in the information system. It is not necessary to wait for a specific diagnosis or microbiologic confirmation before initiating appropriate precautions when patient assessment clearly indicates a clinical syndrome or risk factors related to a potentially communicable disease. For the patient who has, or is suspected of, having a disease requiring additional precautions it is important to institute these precautions immediately. They may be instituted by any health-care provider as soon as the communicable disease, clinical presentation, or risk factors are suspected or identified.*
SIPC4.1.2	**M**	For patients with a known or potential communicable disease, appropriate staff are notified of additional precautions required.
SIPC4.1.3	**M**	Staff comply with infection control policies and protocols when dealing with patients on isolation precautions.
SIPC4.1.4	**M**	Patients with a known or potential communicable disease are placed directly into a single room and do not wait in a common waiting room or, if a single room is not available, the patient is placed in an area of the waiting room separated from other patients by at least 2 meters, and time spent in the waiting room is minimized. *Intent: This is if infection is spread by droplet route. If spread by aerosol route, e.g. chicken pox or measles, the 2 meter distance does not apply.*
SIPC4.1.5	**M**	The patient wears a procedure mask if they are coughing or sneezing and hand hygiene is offered when appropriate.
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.*
SIPC4.1.7		An appointment is scheduled at the end of the day or alternative measures are taken to minimize exposure to other patients.

No.		Description
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.
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.

SIPC5.1		**There is a defined follow-up process that addresses possible or actual blood and body fluid exposure.**
SIPC5.1.1	**M**	There are documented policies and procedures for follow-up to blood and body fluid exposure.
SIPC5.1.2	**M**	For blood and body fluid exposure the staff member has local first aid administered, if required, and then is immediately referred for medical assessment (within 2 hours), appropriate therapy and follow up. *Guidance: It is preferable to go to an emergency department as they have the necessary medications on site, rather than a family physician who does not have the medications in his/her office.*
SIPC5.1.3	**M**	An incident investigation is completed for all staff who have had a potential or actual blood or body fluid exposure.
SIPC5.2		**Safe and effective practices are followed for the use and disposal of sharps.**
SIPC5.2.1	**M**	Safety engineered sharps or devices that have built in safety mechanisms are used.
SIPC5.2.2	**M**	Used needles and other sharp instruments are not recapped.
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.*
SIPC5.2.4	**M**	Sharps containers are sealed and replaced when they are full up to the fill line.
SIPC5.2.5	**M**	Sharps containers are appropriately disposed.

Cleaning of surfaces and ancillary medical equipment

No.	Description

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

No.		Description
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.
SIPC6.1.2	**M**	Equipment and surfaces in direct contact with a patient or blood and body fluid are cleaned and disinfected before use with another patient.
SIPC6.1.3	**M**	A barrier (sheet or paper) is placed on the procedure table and changed between patients. Alternatively, the table is cleaned between patients.
SIPC6.1.4	**M**	If there is significant environmental contamination (e.g. from stool, urine, wound drainage, or uncontrolled respiratory secretions) all horizontal surfaces and frequently touched surfaces are appropriately cleaned and disinfected before the room and/or equipment is used for another patient.
SIPC6.1.5	**M**	Paper liners, linens, patient gowns, etc. are appropriately disposed of or laundered between patients.
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.*

Quality improvement

Introduction

To improve the quality and safety of services provided to patients, the diagnostic service must continuously evaluate its performance and use this information to identify ways that it can improve. This form of self-evaluation must be planned and ongoing, and must focus on systems, processes and the performance of individuals integral to the diagnostic and/or clinical process. Standardizing key processes and documenting best practices allows for the collection and analysis of data concerning the current performance of the key processes. This information can be used to focus improvement activities, and monitor the implementation of changes resulting from a structured continuous quality improvement process.

Every organization and diagnostic service, regardless of size, practices quality improvement to some degree. In some organizations, quality improvement may be highly formalized with comprehensive quality improvement plans and structures. In other organizations, quality improvement may be far less formal.

The quality improvement section of the accreditation standards addresses:

- establishing an integrated and coordinated quality improvement program
- providing leadership and structure to the quality improvement program
- evaluating operational processes through internal audit
- evaluating clinical quality through clinical audit and medical peer review
- proactively identifying and managing clinical risk
- using performance measures to monitor clinical and operational quality

Quality improvement program (QIP)

Introduction

The purpose of a quality improvement program (QIP) is to objectively and systematically monitor and evaluate the quality and appropriateness of services provided, and to pursue opportunities for improvement. For a QIP to be effective, it must be integrated into organization-wide improvement efforts and have assigned leadership and oversight. A QIP consists of the integrated and coordinated activities including operational and clinical audit, clinical risk management and quality assurance and control activities. The size and structure of the organization and the diagnostic service will direct how comprehensive and resourced the QIP is.

No.	Description
SQI1.0	**THERE IS AN INTEGRATED AND COORDINATED QUALITY IMPROVEMENT PROGRAM (QIP).**
SQI1.1	**The diagnostic service has a quality improvement committee.**
SQI1.1.1	There are terms of reference for the quality improvement committee.
SQI1.1.2	The committee is chaired by a leader within the diagnostic service.
SQI1.1.3	The committee is accountable to an organization-wide quality improvement body.
SQI1.1.4	The membership of the committee includes medical, technical and administrative staff of the diagnostic service, and other non-diagnostic service representatives as appropriate.
SQI1.2	**There is a written description of the quality improvement program.**
SQI1.2.1	The objectives of the QIP are identified and aligned with organization-wide quality improvement structures and initiatives.
SQI1.2.2	There is an explicit definition of how quality is defined in the diagnostic service.
SQI1.2.3	The roles, responsibilities and authorities of all individuals and structures of the QIP are defined. *Guidance: The responsibility for the QIP may be assigned to an individual or to the quality improvement committee.*
SQI1.2.4	The QIP is accountable to the governing body/ownership.
SQI1.2.5	The QIP is evaluated on an ongoing basis.
SQI1.3	**Quality improvement initiatives are planned, implemented and evaluated.**
SQI1.3.1	Performance data is used to identify and prioritize improvement opportunities.
SQI1.3.2	Appropriate people (staff, stakeholders, clients) are involved in improvement initiatives.
SQI1.3.3	Clear, measurable statements are developed explaining the goal(s) of each improvement initiative.
SQI1.3.4	Plans for improvement initiatives are developed, documented and implemented.
SQI1.3.5	Quality improvement initiatives are evaluated after implementation.
SQI1.3.6	Action is taken if an initiative does not achieve or sustain planned improvements.
SQI1.3.7	The results of improvement initiatives are documented and communicated to staff, stakeholders and clients.

Key operational processes and internal audits

No.	Description
SQI2.0	**THE DIAGNOSTIC SERVICE IMPROVES QUALITY BY DOCUMENTING AND AUDITING KEY OPERATIONAL PROCESSES.**
SQI2.1	**Key operational processes are defined and documented.** *Guidance: Operational processes are those activities that are necessary to support the effective delivery of care and service.*
SQI2.1.1	**M** Key operational processes that can impact the quality of service are identified.
SQI2.1.2	Processes critical to the diagnostic service are identified and validated.
SQI2.1.3	Identified processes are documented through flowcharting and/or written procedures.
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.*
SQI2.2.1	**M** Clinical processes and procedures that can impact quality of service are identified.
SQI2.2.2	Identified processes and procedures are documented through flowcharting and/or written procedures or protocols.
SQI2.3	**An internal audit program is established to monitor key operational processes.** *Guidance: Internal audits ensure compliance with documented procedures and flowcharts, identify potential risks and opportunities for improvement.*
SQI2.3.1	M Internal audits of key operational processes are performed.
SQI2.3.2	Individuals involved in internal auditing are provided with training.
	Procedures for conducting internal audits are documented and include:
SQI2.3.3	• name of the key operational process
SQI2.3.4	• frequency of audit
SQI2.3.5	• individual appropriate to conduct the audit *Guidance: It is preferable that individuals do not audit their own activities.*
SQI2.3.6	• methodology to conduct the audit and document the results
SQI2.3.7	• responsibility for audit review and follow-up activities
SQI2.4	**Internal audits are performed in the following areas:**
SQI2.4.1	• governance and leadership (e.g. the review of quality and safety reports by the governing body/ownership)

No.	Description
SQI2.4.2	• medical staff (e.g. transfer of function)
SQI2.4.3	• human resources (e.g. the process to assess the competence of staff)
SQI2.4.4	• patient and client focus (e.g. the process to assess patient satisfaction)
SQI2.4.5	• safety (e.g. patient identification or processes to conduct safety inspections)
SQI2.4.6	• information management (e.g. privacy and confidentiality processes)
SQI2.4.7	• quality improvement (e.g. medical peer review process)
SQI2.4.8	• informatics (e.g. data security and integrity)

Clinical processes and risk management

Introduction

Clinical processes, unlike operational processes, focus on specific tasks performed within a health-care setting that can directly affect patient care.

Clinical risk management involves the identification and management of risks associated with the diagnostic and patient care process. Clinical risks involve those aspects of the diagnostic and patient care process that could cause harm to a patient.

Clinical audits are the systematic review of patient care processes to improve health outcomes. A clinical audit involves identifying a specific clinical process, typically those that have been identified as "high risk," setting measureable criteria and goals and collecting data in the form of performance indicators.

No.	Description
SQI3.0	**THE DIAGNOSTIC SERVICE IMPROVES CLINICAL QUALITY BY DOCUMENTING AND AUDITING CLINICAL PROCESSES AND PROCEDURES.**
SQI3.1	**Clinical processes and procedures are defined and documented.**
SQI3.1.1	**M** Clinical processes and procedures that can impact the quality of service are identified.
SQI3.1.2	Identified processes and procedures are documented through flowcharting and/or written procedures or protocols.
SQI3.2	**Clinical processes/procedures are identified and assessed as high or low risk to cause harm.** *Guidance: The determination of the risk level to a patient or individual considers the magnitude of potential harm, and the likelihood of occurrence.*

No.		Description
SQI3.2.1	M	Risk assessments are conducted to identify high-risk clinical processes and procedures.
SQI3.2.2		A record of risk assessments is maintained that includes the assignment of risk level.
SQI3.3		**An internal audit program is established to monitor clinical processes.**
SQI3.3.1	M	Internal audits of clinical processes and procedures are performed. *Guidance: At a minimum, high-risk clinical processes are audited every six months.*
SQI3.3.2	M	Findings from internal audits of clinical processes are reviewed and analyzed.
SQI3.3.3	M	Processes are changed as necessary to reduce risks.

Medical peer review

Introduction

Medical peer review contributes to improving processes and outcomes by providing performance feedback to physicians. It is a proactive tool for identifying, tracking and resolving inappropriate clinical performance, discrepancies and medical errors during all stages of the diagnostic process. Peer review can be an internal process undertaken by peers within the organization, or a process external to the organization utilizing outside peers. Peer review may be performed on a "case-by-case" basis in relation to critical incidents, complaints or medical staff reappointment processes. It may also be performed on randomly selected cases as part of a systematic effort to monitor performance of practitioners as a proactive complement to routine performance data collection and review.

No.		Description
SQI4.0		**THE DIAGNOSTIC SERVICE IMPROVES QUALITY THROUGH A MEDICAL PEER REVIEW PROGRAM.**
SQI4.1		**There is an established medical peer review program.**
SQI4.1.1	M	Medical leadership for the medical peer review program is assigned.
SQI4.1.2	M	The medical leader is responsible to ensure the medical peer review program is developed, implemented and monitored.
SQI4.1.3	M	The medical leader is responsible to ensure the focus of the peer review program is quality improvement.
SQI4.1.5	M	The medical leader is responsible to ensure individual results of medical peer review are communicated to the medical practitioner.

No.		Description
SQI4.1.6	M	The medical leader is responsible to ensure aggregate results of medical peer review are communicated to the diagnostic service medical practitioners.
SQI4.1.7	M	The medical leader is responsible to ensure changes in practice are implemented, as necessary
SQI4.2	**The medical peer review program includes the following minimum elements.**	
SQI4.2.1	M	A defined number of cases and reports are randomly selected for medical peer review for each interpreting physician on a semi-annual 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.*
SQI4.2.2	M	The completeness and accuracy of reporting is assessed. *Guidance: Medical peer review assessment templates are available on the DAP website: https://www.cpsbc.ca/programs/dap/accreditation/polysomnography.*
SQI4.2.3	M	The number of cases reviewed is recorded and reported. *Guidance: Medical peer review annual summary templates are available on the DAP website: https://www.cpsbc.ca/programs/dap/accreditation/polysomnography.*
SQI4.2.4	M	Significant discrepancies between primary report and review are recorded and reported.

Performance indicators

Introduction

In order to improve the quality and safety of services provided, it is important to measure and analyze the performance of processes and then use that data to make improvements. Most organizations have limited resources and cannot collect data to monitor everything. Organizations must choose clinical and operational processes and outcome indicators most important to monitor the quality and safety of the services they provide.

No.		Description
SQI5.0	**INDICATORS ARE USED TO MONITOR OPERATIONAL AND CLINICAL PERFORMANCE.**	
SQI5.1	**Indicators are developed to monitor and improve performance.**	
SQI5.1.1	M	Indicators are developed to monitor the quality and safety of the diagnostic service.
SQI5.1.2		Indicators are used to identify current status and areas for improvement.

No.	Description
SQI5.1.3	Indicators are rate-based (contain a numerator and denominator).
SQI5.1.4	Indicators have defined reporting periods.
SQI5.1.5	Indicators give direction to quality improvement activities.
SQI5.2	**Indicators are established to monitor performance in the following *operational* areas:**
SQI5.2.1	• medical staff (e.g. the frequency of visits by the medical leader to facilities with offsite medical leadership)
SQI5.2.2	• human resources (e.g. staff competency assessment rate)
SQI5.2.3	• safety (e.g. patient injury rate, adverse drug events)
SQI5.2.4	• patient and client focus (e.g. wait time from referral to test)
SQI5.2.5	• quality improvement (e.g. medical peer review discrepancy rate)
SQI5.2.6	• information management (e.g. reported breaches in confidentiality)

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.

The information management section of the accreditation standards addresses:

- planning
- confidentiality
- medical records
- document control
- retention of documents and records

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.*
SIM1.1	**The information management plan for the diagnostic service includes:**
SIM1.1.1	• participation of key stakeholders (e.g. medical, management, technical staff, referring physicians, etc.)
SIM1.1.2	• identification of the information needs of medical and administrative leaders
SIM1.1.3	• identification of processes to manage management and clinical information
SIM1.1.4	• activities for managing interruptions to information systems so that access to information is maintained
SIM1.1.5	• priority of current and future information needs

No.	Description
SIM1.1.6	• alignment with organization wide information management processes and plans
SIM1.1.7	• communication of plans and priorities to the administration of the organization
SIM1.1.8	• adequate resources secured for implementation and sustainability of information management processes
SIM1.2	**The diagnostic service regularly reviews processes for the management of information that includes:**
SIM1.2.1	• organization (e.g. standardization and categorization) • *Intent: The use of uniform data sets to standardize data collection throughout the organization and the standard use of terminology, abbreviations, symbols, etc. is essential for effective information management.*
SIM1.2.2	• collection (e.g. capture or acquisition)
SIM1.2.3	• communication
SIM1.2.4	• archive and storage
SIM1.2.5	• access, security and confidentiality
SIM1.2.6	• information system performance
SIM1.2.7	• diagnostic reports linked with tests
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.
SIM1.3.2	There are provisions for ongoing information user training.
SIM1.3.3	Documentation is provided to users as needed.

SIM2.0 INFORMATION IS AVAILABLE AND USED TO MAKE EFFECTIVE DECISIONS.

Guidance: The exclusive use of a paper-based information system may limit the availability of management information used to support decisions compared to an electronic system; however, the system still needs to support clinical and management decisions at a level appropriate for the diagnostic service.

SIM2.1	**Information management processes used to support clinical and management decisions allow the diagnostic service leaders to:**
SIM2.1.1	**M** access data in a timely fashion
SIM2.1.2	**M** gather, link and combine data and information from multiple sources
SIM2.1.3	**M** assess and compare current data to historical data

No.		Description
SIM2.1.4		determine costs associated with service delivery
SIM2.1.5		manage resource utilization
SIM2.1.6		exchange information with other organizations, as appropriate
SIM2.1.7		routinely obtain clinical and management reports

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.*
SIM3.1.2		The disaster recovery plan has been tested.
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.).
SIM3.2		**Downtime procedures are available and communicated to staff.** *Intent: Downtime procedures are required for both scheduled and unscheduled system downtime.*
SIM3.2.1	**M**	Documented downtime procedures are available and communicated to staff.
SIM3.2.2	**M**	Users know how to contact support staff in the event of system and/or equipment malfunction.
SIM3.2.3		On-site or consultant information system specialists are available in a timely manner in case of a system malfunction.
SIM3.2.4		Adequate resources are made available for downtime recovery.
SIM3.2.5		The reasons for, and frequency of, information system downtime is documented.
		Designated staff and/or information system specialists are available and perform the following:
SIM3.2.6		• assess and participate in problem-solving
SIM3.2.7		• initiate repair and follow-up
SIM3.2.8		• data reconciliation and correction

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.
SIM4.1.4	**M**	Unauthorized user access is monitored.
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.
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).
SIM4.1.9	**M**	Security incidents are reported, documented, investigated and resolved. Actions are taken to prevent recurrence.
SIM4.2	**The service has policies for the release or destruction of data.**	

No.		Description
		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
SIM4.2.11		Personal information that is subject to restricted access is identified.
SIM4.2.12	**M**	Confidential data is destroyed appropriately.

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.
SIM5.1	**The medical record includes accurate patient identification information.**

No.		Description
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.*
SIM5.2		**Data integrity is monitored and maintained.**
SIM5.2.1	**M**	There are policies and procedures for reporting and reconciling of data entry errors and patient identification issues.
SIM5.2.2	**M**	Reconciliation is performed by authorized individuals.
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.*
SIM5.2.4	**M**	Information captured from other organizations is verified (manually or electronically) for accuracy prior to user access. *Intent: There can be risks with associating external information with internal patient medical records. Procedures exist to ensure data integrity and deal with discrepancies in information from external organizations.*
SIM5.3		**Current and historical clinical data can be accessed by staff and clients when needed.**
SIM5.3.1	**M**	Test data and reports are available when the patient moves from one facility to another. *Guidance: Stored test data and diagnostic reports are available in an appropriate format (e.g. printed, electronic) or are readily accessible in soft copy for off-site review.*
SIM5.3.2		Storage allows for the availability and linking of multiple studies and diagnostic reports for individual patients.
SIM5.3.3		Data is retrievable for a designated period of time, depending on the needs of the diagnostic service.
SIM5.3.4		Storage capacity planning is periodically performed to ensure the storage needs of the diagnostic service are maintained.
SIM5.3.5	**M**	There is sufficient storage for hardcopy records (including test data).

Document control

No.		Description
SIM6.0		**THE DIAGNOSTIC SERVICE DEFINES AND MAINTAINS PROCEDURES TO CONTROL KEY OPERATIONAL DOCUMENTS.** *Guidance: This standard refers to key documents such as operational policies and procedures. Documentation may be paper-based (e.g. manuals) or in electronic format.*
SIM6.1		**The diagnostic service defines and maintains document control procedures.**
SIM6.1.1	**M**	There are defined individuals, procedures and processes for the maintenance and review of documents.
SIM6.1.2		There is a list of controlled documents that identifies the current version and distribution. *Guidance: In some organizations and facilities, a document is distributed to one or more locations or areas. Examples of this include clinics in hospitals, regional systems and other departments within a facility.*
		Documents are well marked and uniquely identified to include:
SIM6.1.3	**M**	• title
SIM6.1.4	**M**	• current revision date or version
SIM6.1.5	**M**	• identification of the individual responsible for the authorization and release of the document
SIM6.1.6	**M**	Documents follow a standardized format.
SIM6.1.7	**M**	Only current authorized versions of documents are available and invalid or obsolete documents are promptly removed from all points of use.
SIM6.1.8	**M**	Operational documents are archived for later reference and archival time is defined.
SIM6.1.9	**M**	Where handwritten amendments are permitted, the amendments indicate date of entry and identification of the person making the change.
SIM6.1.10		Handwritten amendments are permanently incorporated into procedures, and documents are reissued within six months.
SIM6.2		**There are processes to address changes in procedures and documentation.**
SIM6.2.1	**M**	New or revised policies, procedures and protocols are communicated and available to staff.
SIM6.2.2	**M**	Communication is recorded.

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."
		Retention times are identified for the following
SIM7.1.3		• request forms
SIM7.1.4		• test protocols
SIM7.1.5		• quality improvement records
SIM7.1.6		• records of internal and external audits
SIM7.1.7		• complaints and actions taken
SIM7.1.8		• adverse event and/or critical incident reporting forms and records of investigation
SIM7.1.9		• staff training and orientation records
SIM7.1.10		• staff competency records
SIM7.2		**Equipment testing records are retained.**
SIM7.2.1	**M**	Preventative maintenance records are retained for the lifetime of the equipment.
SIM7.2.2	**M**	A log for scheduled safety checks is maintained.

Equipment and supplies

Introduction

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

The equipment and supplies section of the accreditation standards addresses:

- equipment operation
- equipment testing
- solutions and supplies

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
SES1.1.2	**M**	• manufacturer
SES1.1.3	**M**	• serial number or other identifier
SES1.1.4	**M**	• date of installation
SES1.1.5	**M**	• condition of equipment at the time it was acquired (e.g. new, refurbished)
SES1.1.6	**M**	• safety check and verification documentation for new and used equipment
SES1.1.7	**M**	• preventative maintenance records
SES1.1.8	**M**	• repair records
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.

No.		Description
SES1.2.2	**M**	Specialized equipment and instrumentation is operated by competent staff with the necessary education, knowledge, skills and certification.
SES1.2.3	**M**	Equipment is used only as intended by the manufacturer.
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.
SES1.2.6		Equipment is located to maximize efficiency.
SES1.3		**The diagnostic service investigates and resolves problems involving all equipment.**
SES1.3.1	**M**	Roles and responsibilities for reporting, investigating and resolving equipment problems are clearly communicated and understood.
SES1.3.2	**M**	There is a list of service staff and their contact information.
SES1.3.3	**M**	Responsible staff members are trained in resolving equipment problems.
SES1.3.4	**M**	Information about problems is collected, documented, monitored and analyzed.
SES1.3.5	**M**	Actions to prevent recurrence are identified.
SES1.3.6	**M**	Manufacturer-issued defects, recalls and safety advisories are acted upon immediately.
SES1.3.7	**M**	There is a process for resolving non-compliance or quality issues with the vendor in a timely manner.
SES1.3.8	**M**	Equipment problems that impact test quality or safety are reported and repaired.
SES1.3.9	**M**	Any equipment that is not functioning as per manufacturer guidelines or poses a safety risk is clearly labeled and removed from service.
SES1.3.10	**M**	Any equipment that exhibits performance limitations, but is deemed safe, is identified to all relevant staff.
SES1.3.11	**M**	Equipment and other instruments are new, relocated or entering into service after repair are calibrated, validated and verified, as appropriate, before patient results are reported.
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*.

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.

No.		Description
SES2.1.2	**M**	The tester is independent of the manufacturer.
SES2.1.3		Results from the safety testing are used to establish baseline values and operational performance for the equipment.

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.
SES3.1.2		Receipt and service entry dates are recorded as necessary.
SES3.1.3	**M**	Expiration dates are monitored.
SES3.1.4		Rejected/expired goods are clearly marked and dealt with appropriately.
SES3.1.5		Inventory control problems and actions taken are documented.
SES3.1.6		There is a process for resolving non-compliance or quality issues with the vendor in a timely manner.
SES3.1.7		Documentation of supply utilization is routinely reviewed.
SES3.1.8		There are policies and procedures for the appropriate disposal of solutions and supplies.

Global polysomnography

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

The global section of the accreditation standards addresses:

- test requests
- patient preparation
- diagnostic procedures
  - protocols
  - sedation and anesthesia
  - medical record

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.*
GS1.1		**Processing of the test requests ensures:**
GS1.1.1	**M**	• tests are only performed when requested by authorized individuals *Guidance: There is a facility policy that defines "authorized individual" that includes medical physicians and other designated health professionals as permitted by governing legislation, rules and bylaws.*
GS1.1.2	**M**	• verbal requests are immediately followed with an authorized electronic or written request
GS1.1.3	**M**	• requests that lack the necessary information or contain errors are reconciled prior to the test
GS1.1.4		• authorized individuals requesting tests are notified when tests are cancelled by the diagnostic service
GS1.2		**The appropriateness of requested diagnostic services is assessed.**
GS1.2.1		Clinical indications for requesting tests are made available.
GS1.2.2	**M**	Processes are in place to assess test appropriateness.
GS1.3		**Requests contain accurate and appropriate information that includes:**

No.	Description		
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.**	
GS2.1	**Patient instructions are clearly communicated.**	
GS2.1.1	**M**	Patients or supporting individuals are advised of patient instructions prior to the test, as needed.
GS2.1.2		Patient instructions are available in a variety of languages considering the population served.
GS2.1.3		There are processes to identify and work with patients who do not speak English.
GS2.1.4		Multi-lingual staff are identified and available where practical and in accordance with the diagnostic service policy.
GS2.2	**Pre-test information is collected and assessed prior to commencing the test.**	

No.		Description
GS2.2.1		Any factors that may affect the test are documented and considered.
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.*
GS2.2.3		Patient histories are obtained and relevant clinical history is recorded. *Guidance: A patient's medical condition may change if a reasonable wait time from point of referral to test is exceeded.*
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.**
GS3.1		**There is a process to ensure that procedural documents are reviewed.**
GS3.1.1	**M**	Procedures are reviewed every 1-3 years by qualified individual(s).
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).*
GS3.2.3	**M**	Manufacturer's documentation is only used as a supplement to the diagnostic facilities procedure. *Intent: There should be documentation for all diagnostic procedures performed at the facility. Equipment or product information supplied by the manufacturer may be used to supplement procedural documentation but cannot be used as a substitute.*
GS3.2.4	**M**	Manufacturer's changes to procedures are incorporated in a timely manner.
GS3.3		**Testing is performed according to established procedures.**

No.		Description
GS3.3.1	**M**	Diagnostic testing is consistent with the procedures in manuals.
GS3.4		Procedure manuals are current, accurate and available to staff.
		All the information necessary to perform the test is available and includes:
GS3.4.1	**M**	• name of test
GS3.4.2	**M**	• equipment used
GS3.4.3	**M**	• testing techniques (e.g. pre-procedure documentation, skin preparation, electrode placement)
GS3.4.4	**M**	• recording procedure
GS3.4.5		• normative values
GS3.4.6		• special precautions
GS3.4.7	**M**	• references/guidelines used in the development of the procedures

Medical record

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

No.	Description		
GS4.2.2	**M**	•	technologist performing test
GS4.2.3	**M**	•	date and time of test
GS4.2.4	**M**	•	relevant medication information (e.g. substance, route, identity of person administering)
GS4.2.5	**M**	•	deviations from the standard procedure and the reason for deviation
GS4.2.6		•	relevant clinical information provided by the patient or observed complications pertinent for interpretation purposes

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
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.*

No.	Description
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
GS5.2	**Reports contain sufficient information to assist in diagnosis.** *Intent: When required, previous reports are promptly available for review and comparison with the current test. A request for diagnostic test includes relevant clinical information, a working diagnostic or pertinent clinical signs and symptoms and may include specific clinical questions to be answered in the final report. Such information helps tailor the most appropriate diagnostic test to the clinical scenario, enhances the clinical relevance of the report, and thus promotes optimal patient care.*
GS5.2.1	Standardized report templates are used.
	The body of the report includes the following:
GS5.2.2	**M** • procedures performed *Guidance: The report includes a description of the studies or procedures performed, medications, equipment used, relevant patient preparation and positioning details.*
GS5.2.3	**M** • findings *Guidance: The report uses appropriate anatomic, pathologic, and diagnostic terminology to describe the findings.*
GS5.2.4	**M** • potential limitations *Guidance: The report, when appropriate, identifies factors that may compromise the test. Any known significant patient reaction or complication is recorded.*
GS5.2.5	**M** • clinical issues or concerns *Guidance: The report addresses or answers any specific clinical questions.*
GS5.2.6	**M** • the impression (e.g. conclusion or diagnosis) section of the report *Guidance: Unless the report is brief, each report contains an "impression" section.*
GS5.2.7	**M** • comparison with relevant tests and reports is included in final report
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.*
GS5.3.1	**M** Final reports are issued for all tests.
GS5.3.2	The final report is verified by the reporting physician to minimize typographical errors, accidentally deleted words, and confusing or conflicting statements.
GS5.3.3	**M** Verified reports are signed by the reporting physician.
GS5.3.4	**M** If the content of the report is not verified by the author, it is clearly indicated on the report.

No.		Description
GS5.3.5	**M**	If the content of the report has **not** been verified by the author, there is a process in place to verify the accuracy of the transcription.
GS5.3.6	**M**	A copy of the final report is archived by the diagnostic service as part of the patient's medical record (paper or electronic) and is retrievable for future reference.
GS5.3.7	**M**	Medical staff responsible for the patient is notified of report delays in variance with established turnaround times and in cases that may compromise patient care.
GS5.3.8		The use of abbreviations or acronyms is limited to avoid ambiguity.

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.*
GS6.1		**Preliminary reports provide information necessary for clinical decision-making.** *Intent: Preliminary reports may be communicated in a written, electronic, or verbal format. Preliminary reports may be time sensitive, and are not expected to contain all the reportable findings. A preliminary report may not have the benefit of prior diagnostic studies and/or reports and may be based upon incomplete information due to evolving clinical circumstances. Nevertheless, clinical decision-making may be based on this report due to the need for immediate patient management. Situations that may require preliminary reports may include interpretations provided to emergency departments, surgical departments and critical care units.*
GS6.1.1	**M**	Preliminary reports are clearly identified as such.
GS6.1.2	**M**	All preliminary reports are followed by a final report.
GS6.1.3	**M**	Medical staff responsible for the patient are notified as soon as possible when there is a significant discrepancy between a preliminary and the final written report.
GS6.1.4	**M**	Communication of any discrepancy between a preliminary and final report is incorporated into the final report.

No.		Description
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.*
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.
GS6.2.2	**M**	Appropriate medical staff is notified by direct means (e.g. in person or by telephone) according to facility policy for communication of urgent and other non-routine findings (e.g. critical results).
GS6.2.3	**M**	Contingency plans are available in the event that the medical staff cannot be contacted.
		Notification and actions taken in response to urgent, unexpected or unusual findings are documented, including: *Guidance: The name of person to whom communication was made, the date and time and method of communication is documented.*
GS6.2.4	**M**	the urgent findings
GS6.2.5	**M**	name of the person to whom the findings were given
GS6.2.6	**M**	date and time
GS6.3		**There are policies and procedures in place to deal with corrected and addendum reports.** *Guidance: There are clear directions for staff that indicate when a corrected report or addendum report is required (this may be done through the use of examples), and the steps that must be taken when issuing a corrected or addendum report. There should be guidance as to when clinical staff should be informed of a corrected or addendum report or when a physician should be alerted about a corrected or addendum report. Clear identification that the report has been corrected or added to should be followed by the new result and then the original result.*

No.	Description	
GS6.3.1	**M**	There are policies and procedures that address corrected and addendum reports.
GS6.3.2	**M**	Corrected and addendum reports are clearly identified.
GS6.3.3	**M**	Both the original and the new results are reported.
GS6.3.4	**M**	The date and time the change or addition was made are recorded.
GS6.3.5	**M**	The identity of the person making the change or addition is recorded.
GS6.3.6	**M**	Notification of clinical staff is recorded when there is a significant discrepancy between the original and the corrected or addendum report.

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.

Patient preparation

No.		Description
PSG1.0		**PATIENTS ARE PREPARED FOR THE TEST BEING PERFORMED.** *See also Global Accreditation Standards GS 2.0.*
PSG1.1		**Patient preparation instructions are clearly communicated.**
PSG1.1.1	M	A consultation letter is provided by the referring physician or specialist.
PSG1.1.2	**M**	A current medication list is reviewed and any recent medical change is documented prior to testing.
PSG1.1.3	**M**	Current medical and physical history and other patient specific factors are documented and considered prior to patient testing.
PSG1.1.4	**M**	Patients are orientated to the preparation/testing schedule; which includes a description of hook-up and lights on/off procedures.
PSG1.1.5	**M**	Patients are orientated to their sleep room, bathroom/changing area, and where to access food, water, etc.
PSG1.1.6	**M**	Patients are informed of the procedure to contact staff for assistance, or in case of emergency.

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.**

No.		Description
PSG2.1.1	**M**	A biological calibration is done at the beginning of the test and is available for review.
PSG2.1.2	**M**	Amplifier calibration *(sometimes referred to as machine calibration)* is performed at the beginning and end of each test. *Intent: To ensure the voltage going into the amplifier is not degraded from the beginning to the end of the study.*
PSG2.1.3	**M**	Electrode impedance verification is performed at the beginning of the test and is available for review.
PSG2.1.4	**M**	The recording time in bed (lights-out to lights-on) is for a minimum of six hours. Variances from this must be documented.
PSG2.1.5		Patients are encouraged to sleep in the supine and lateral positions.
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.
PSG2.1.7		Montage derivation is recorded including sensitivities, filtration settings and voltage changes. *Guidance: Limited filter settings and changes are applied when trying to achieve a good quality signal.*
PSG2.1.8	**M**	An electroencephalogram (EEG) is recorded during polysomnography testing. *Guidance: The EEG recording uses a minimum of three channels e.g. Central, Frontal, and Occipital.*
PSG2.1.9	**M**	An electrooculogram (EOG) is recorded during polysomnography testing. *Guidance: The EOG recording uses a minimum of two channels.*
PSG2.1.10	**M**	An electromyogram (EMG) using is recorded during polysomnography testing. *Intent: The EMG recording uses three channels for submental and two channels per leg for tibialis muscles.*
PSG2.1.11	**M**	An electrocardiogram (ECG) is recorded during polysomnography testing.
PSG2.1.12	**M**	The airflow (types: nasal pressure transducer and thermacouple) is recorded during polysomnography testing.
		Documentation of CPAP/BiLevel parameters includes:
PSG2.1.13	**M**	• the type or model of CPAP/BiLevel machine
PSG2.1.14	**M**	• the type of CPAP/BiLevel interface (nasal or full face mask)
PSG2.1.15	**M**	• CPAP/BiLevel airway pressure settings
PSG2.1.16	**M**	• a notation of interface leakage or air leak

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.*

No.		Description
PSG2.2.1	**M**	The technical staff members have training and experience in dealing with children.
PSG2.2.2	**M**	All factors are considered prior to testing e.g. developmental disorders, neurological, pulmonary or cardiac diseases.
PSG2.2.3		Time in bed (lights-out to lights-on) is for a minimum of six hours.
PSG2.2.4		In patients with obstructive sleep apnea, treatment may be instituted with nasal positive airway pressure and the optimal pressure determined.
PSG2.2.5	**M**	Resting furniture is available for the parent/guardian during testing.

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.*
PSG2.3.1	**M**	The patient is assessed for relative and absolute contraindications prior to initiating the therapy.
PSG2.3.2	**M**	The patient is given instructions on how to use the equipment prior to testing.
PSG2.3.3	**M**	The rationale for initiating therapy is documented.
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.*
PSG2.3.5		During a split-night study a minimum three hours of therapeutic data is collected. *Intent: When a split-night study is performed only one form of therapy is evaluated.*
PSG2.3.6	**M**	Guidelines for converting to CPAP titration or adjunct therapy are defined.

Positive airway pressure titration (PAP)

PSG2.4		**PAP titration tests are standardized and recorded in a manner that ensures accurate results for interpretation.**
PSG2.4.1	**M**	The patient is given instructions on how to use the equipment prior to testing.
PSG2.4.2		All factors are considered to achieve optimal PAP pressure.
PSG2.4.3	**M**	Mask fitting is assessed prior to initiating therapy to ensure minimal leaks and optimal patient comfort.
		Titration guidelines are defined for:
PSG2.4.4	**M**	CPAP titration

No.		Description
PSG2.4.5	**M**	supplemental oxygen
PSG2.4.6	**M**	adapted servoventilation (ASV)
PSG2.4.7	**M**	average volume assured pressure support ventilation (AVAPS)

PSG3.0 DAYTIME TESTS ARE COMPREHENSIVE AND PROVIDE ALL THE NECESSARY INFORMATION.

Multiple sleep latency tests (MSLT)

PSG3.1		**Multiple Sleep Latency Tests (MSLT) are standardized and recorded in a manner that ensures accurate results for interpretation.**
PSG3.1.1	**M**	The overnight polysomnogram results are reviewed by the technologist prior to MSLT.
PSG3.1.2	**M**	The MSLT is performed 1.5–3 hours after the overnight polysomnogram. *Guidance: A minimum of 5 hours of testing is established prior to testing.*
PSG3.1.3	**M**	The MSLT consists of a minimum of four, twenty minute nap opportunities scheduled at specific times during the day, with a 2 hour interval between naps or starting time.
PSG3.1.4	**M**	When sleep is seen in the first 20 minutes of the recording an additional 15 minutes of recording time is added.
PSG3.1.5	**M**	A fifth nap is performed when there is evidence for an abnormal REM intrusion or a mean sleep latency of 10 minutes or less during the first four nap opportunities.
PSG3.1.6	**M**	During periods between sleep opportunities, patients are monitored for wakefulness. *Intent: The technologist ensures that the patient stays awake between tests (eg. through direct observation or instructions if the patient leaves the sleep lab).*
PSG3.1.7		Vigorous physical activity, bright lights, smoking and caffeine are avoided during periods of wakefulness.
PSG3.1.8	**M**	End of test criteria or early termination protocols are defined.
PSG3.1.9	**M**	Electroencephalogram (EEG) is recorded. *Intent: The EEG recording uses a minimum of three channels e.g. Central, Frontal, and Occipital.*
PSG3.1.10	**M**	Electrooculogram (EOG) is recorded. *Intent: The EOG recording uses a minimum of two channels.*
PSG3.1.11	**M**	Electromyogram (EMG) is recorded. *Intent: The EMG recording uses three channels for submental.*

No.		Description
PSG3.1.12	M	Electrocardiogram (ECG) is recorded.
		MSLT report includes:
PSG3.1.13	M	• the total time for each nap opportunity (lights-out to lights-on)
PSG3.1.14	M	• the documented sleep stages
PSG3.1.15	M	• a test by test listing of latency from lights out to the first sleep epoch
PSG3.1.16	M	• the mean sleep latency
PSG3.1.17	M	• the presence or absence of REM sleep and REM sleep latency
PSG3.1.18	M	• the absence of sleep on any nap opportunity
PSG3.1.19	M	• reason(s) for early test termination
PSG3.1.20	M	• a list of current medications
PSG3.1.21	M	• documentation of patient's intake and physical activity between scheduled naps
PSG3.1.22		• the degree of sleepiness using a standardized sleepiness scale e.g. Stanford Sleepiness Scale

Maintenance of wakefulness tests (MWT)

PSG3.2		**Maintenance of Wakefulness Tests (MWT) are standardized and recorded in a manner that ensures accurate results for interpretation.**
PSG3.2.1		The overnight polysomnogram results are reviewed prior to MWT.
PSG3.2.2		The patient's prior night's sleep and activities are assessed prior to testing. *Guidance: The quality of the sleep the night before can impact the validity of the test.*
PSG3.2.3	M	The patient is seated in a dimly lit room during the test.
PSG3.2.4	M	The patient is required to stay awake for a minimum of forty minutes every two hours.
PSG3.2.5	M	Data is collected from four tests (40 minute periods of wakefulness).
PSG3.2.6	M	End of test criteria or early termination protocols are established and documented.
PSG3.2.7	M	Electroencephalogram (EEG) is recorded. *Guidance: The EEG recording uses a minimum of three channels e.g. Central, Frontal, and Occipital.*
PSG3.2.8	M	Electrooculogram (EOG) is recorded *Guidance: The EOG recording uses a minimum of two channels.*

No.		Description
PSG3.2.9	**M**	Electromyogram (EMG) is recorded. *Guidance:* The EMG recording uses three electrodes for submental.
PSG3.2.10	**M**	Electrocardiogram (ECG) is recorded.
		MWT report includes:
PSG3.2.11	**M**	• the start time for the nap
PSG3.2.12		• the sleep onset latency
PSG3.2.13		• the total sleep time
PSG3.2.14		• the documented sleep stages
PSG3.2.15	**M**	• the mean sleep latency for each nap
PSG3.2.16		• any abnormal findings before or during each nap
PSG3.2.17		• the reason for early termination of test
PSG3.2.18	**M**	• a list of current medications
PSG3.2.19		• the degree of sleepiness is documented (e.g. Stanford Sleepiness Scale)

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

Overnight oximetry

PSG4.1		**Overnight oximetry tests are conducted and recorded in a manner that ensures accurate results.**
		The patient receives instructions on the pulse oximeter that include:
PSG4.1.1	**M**	• turning the oximeter on and off
PSG4.1.2	**M**	• placing and securing the probe
PSG4.1.3	**M**	• ensuring that a good signal is achieved
PSG4.1.4	**M**	• maintenance of a diary
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.*
PSG4.1.6	**M**	The date and time settings of the oximeter are verified prior to testing.

No.		Description
PSG4.1.7	M	Pulse rate and oxygen saturation data are collected for at least four hours. *Guidance: Six hours of data is preferable.*
PSG4.1.8	M	Unedited data is available to the interpreting physician.
		The overnight oximetry data include:
PSG4.1.9	M	• SpO_2% mean
PSG4.1.10	M	• SpO_2% minimum
PSG4.1.11	M	• total time the SpO_2 is below 88%, 85%, and 80%
PSG4.1.12	M	• the desaturation index (the number of 4% desaturations/hour)
PSG4.1.13	M	• heart rate (mean, minimum and maximum)
PSG4.1.14	M	• graphic data of SpO_2 and cardiac rate for the duration of the test
PSG4.1.15	M	• indication of PAP settings (e.g. CPAP or Bilevel)
PSG4.1.16	M	• indication of oxygen conditions (e.g. flow rate)
PSG4.1.17	M	• type of probe used to monitor saturation (e.g. finger, ear or forehead probe)

Actigraphy tests

PSG4.2		**Actigraphy tests are standardized and recorded in a manner that ensures accurate results for interpretation.**
PSG4.2.1		Tests are conducted for a minimum of seven consecutive 24-hour periods.
PSG4.2.2	M	The raw data is available and reviewed prior to interpretation. *Guidance: Automatic scoring may be used in addition to manual methods of scoring/reviewing. Epoch lengths should be limited to a maximum of one minute.*

Four channel portable test

PSG4.3		**The monitoring and recording of the Four Channel Portable Test is standardized and recorded in a manner that ensures accurate results for interpretation.**
PSG4.3.1	M	Tests are only performed on patients that are suspected of having a moderate to high probability of obstructed sleep apnea hypopnea (OSAH) with no comorbidities.
PSG4.3.2		The rationale for initiating four channel polysomnography testing is documented.

No.		Description
PSG4.3.3		A medical history including a sleep questionnaire is obtained prior to testing.
PSG4.3.4	M	A minimum of four hours of data is obtained from all four channels.
PSG4.3.5		A post-test sleep questionnaire is obtained.
PSG4.3.6	M	Testing is manually scored.
PSG4.3.7	M	Raw data is available to the interpreting physician.
		At a minimum, monitoring of four channel polysomnography includes:
PSG4.3.8	M	• respiratory/ventilator effort
PSG4.3.9	M	• nasal pressure
PSG4.3.10	M	• electrocardiogram or heart rate (ECG)
PSG4.3.11	M	• SpO_2% (oxygen saturation)

Measured parameters

PSG5.0 MEASURED PARAMETERS ARE COMPREHENSIVE AND PROVIDE ALL THE NECESSARY INFORMATION FOR INTERPRETATION.

Electroencephalogram (EEG)

PSG5.1		**EEG monitoring and recording is standardized and recorded in a manner that ensures accurate results for interpretation.**
PSG5.1.1	M	Appropriate skin preparation is performed.
PSG5.1.2	M	Abrasive gel is used for lowering impedances.
PSG5.1.3	M	Surface cup/disc electrodes are used for routine EEGs.
PSG5.1.4	M	All electrodes used on a patient are of the same material.
PSG5.1.5	M	If a patient has a head wound, the tape and pencil are discarded.
PSG5.1.6	M	Abrasive gel and cotton-tipped applicators used for skin preparation are discarded after each patient.
PSG5.1.7	M	The head is measured and electrodes are accurately placed according to the International 10-20 Electrode Placement System.

PSG5.1.8	**M**	If electrodes are repositioned due to an anomaly (e.g. skull deformity or defect) the contralateral electrode is placed symmetrically and is documented.
PSG5.1.9	**M**	The EEG recording routinely measures below 5 KOhms. *Guidance: Attempts should be made to have measured impedances below* 5KOhms. *In circumstances where this cannot be achieved the reason is documented.*
PSG5.2	**Montages are standardized in a manner that ensures accurate results.**	
PSG5.2.1	**M**	A minimum of three channels from different areas are recorded *(e.g. central, frontal and occipital).*
PSG5.2.2	**M**	Backup electrodes for central, frontal and occipital channels are placed. *Intent: To reduce disruption of the patient when electrodes are disconnected or poor signal during the PSG.*
PSG5.2.3	**M**	Contralateral referential montages are recorded and attempts are made to reattach electrodes without disturbing the patient.
PSG5.2.4		If contamination occurs, attempts are made to correct the issue. *Guidance: After failed attempts to obtain a good signal re-referencing may be necessary.*
PSG5.2.5		Each montage is fully annotated with the electrodes at each derivation specified.
PSG5.3	**Sensitivity settings are used to ensure accurate and meaningful results for interpretation.**	
PSG5.3.1		Adjustments are made in order to record a wide range of voltage signals.
PSG5.3.2		Sensitivities are expressed in μV/mm or μV P-P (Peak to peak).
PSG5.4	**Filter settings are used to ensure accurate and meaningful results for interpretation.**	
PSG5.4.1	**M**	All filter setting changes are indicated on the recording at the time of change.
PSG5.4.2	**M**	The low frequency (high–pass) filter is set no higher than 1 Hz (-3dB) for the majority of the recording with corresponding time constants of 0.16 seconds.
PSG5.4.3	**M**	The high frequency (low-pass) filter is set no lower than 35 Hz (-3dB) for a portion of the recording.
PSG5.4.4	**M**	The 60 Hz (notch) filter is off and only used when attempts at eliminating 60 Hz interferences have failed.

Electromyogram (EMG)

PSG6.0 EMG MONITORING AND RECORDING IS CONDUCTED IN A MANNER THAT ENSURES THE COLLECTION OF ACCURATE DATA.

PSG6.1	**EMG is monitored during polysomnography.**

		Electrode placement protocols are defined for:
PSG6.1.1	**M**	• chin (3 electrodes = 1 channel) *Guidance: The standard chin EMG derivation consists of two electrodes below the mandible and one electrode above the mandible. The second electrode below the mandible is a backup electrode to allow for continued display of EMG activity if one of the primary electrodes malfunctions.*
PSG6.1.2	**M**	• leg/limb (2 electrodes/leg = 1 channel/leg) *Guidance: Both legs are monitored for the presence of the leg movements.*

Electrooculogram (EOG)

No.		Description
PSG7.0		**EOG MONITORING AND RECORDING IS CONDUCTED IN A MANNER THAT ENSURES THE COLLECTION OF ACCURATE DATA.**
PSG7.1		**EOG is monitored during polysomnography.**
PSG7.1.1	**M**	Electrode placement protocols have been established and documented. *Intent: E1 – M2 is placed 1 cm below the left outer canthus and E2 – M2 is placed 1 cm above the right outer canthus.*

Electrocardiogram (ECG)

No.		Description
PSG8.0		**ECG MONITORING AND RECORDING IS CONDUCTED IN A MANNER THAT ENSURES THE COLLECTION OF ACCURATE DATA.**
PSG8.1		**ECG is monitored during polysomnography.**
PSG8.1.1	**M**	Minimum of 2 ECG leads are placed using torso lead placement. *Guidance: Additional leads may be placed if indicated by the physician.*
PSG8.1.2		Chest hair is removed when required.
PSG8.1.3	**M**	A new razor is used and then discarded into an appropriate sharps container.
PSG8.1.4		The skin is cleansed and prepped as needed to eliminate artifacts in the tracing.
PSG8.1.5		There is a job aid that demonstrates the correct placement of precordial leads.

No.		Description
PSG8.1.6	**M**	Precordial leads are attached to the correct anatomical position.
PSG8.1.7		Cable stabilization is used to reduce motion artifact.
PSG8.1.8	**M**	Any suspected changes on the ECG that require urgent medical attention are documented and includes a printout.

Pulse oximetry

No.		Description
PSG9.0		**PULSE OXIMETRY TESTING IS CONDUCTED IN A WAY THAT ENSURES THE COLLECTION OF ACCURATE DATA.**
PSG9.1		**Pulse oximeter data is validated to ensure the accuracy of testing.**
PSG9.1.1	**M**	An appropriate probe (e.g. finger, ear, nose or forehead) is selected based on the clinical requirements of the patient. *Guidance: Staff should be aware of the limitations of the different devices.*
PSG9.1.2	**M**	A good signal waveform is achieved that correlates with the pulse. *Guidance: Nail polish or artificial acrylic nails are assessed prior to finger probe placement.*
PSG9.1.3	**M**	The accuracy of capture is evaluated by comparing the palpated pulse to the reported heart rate on the device.
PSG9.1.4		Good blood flow is encouraged for a peripheral site probe. *Guidance: Actual physical rubbing may be required to stimulate blood flow.*
PSG9.1.5		Disparity between SpO_2 and SaO_2 readings, or the SpO_2 and the clinical presentation of the patient, is investigated prior to reporting results.
PSG9.1.6		Situations that may affect pulse oximetry results are defined (e.g. abnormal hemoglobin, intramuscular dyes, external sources of motion, ambient light, electrical interferences).
PSG9.1.7		Oximeter types throughout the testing continuum are standardized. *Intent: Since there are differences in accuracy among various oximeter brands and types, the same type of device should be used for serial measurements on a patient.*
PSG9.1.8	**M**	The probe is cleaned between patient applications according to manufacturer recommendations.

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.
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.*

No.		Description
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.**
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

No.		Description
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:
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

No.	Description
	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.

access Ability of clients or potential clients to obtain required or available services when needed within an appropriate time.

accountability Responsibility and requirement to answer for tasks or activities. This responsibility may not be delegated and must be transparent.

accreditation A recognition of the achievement of accreditation standards by a diagnostic facility or organization, demonstrated through an independent external peer assessment of that organization's level of performance in relation to the Diagnostic Accreditation Program's standards, criteria and criterion descriptors.

accreditation body The organization responsible for the accreditation program and the granting of accreditation status.

addendum report A report that is sent when additional information that must be reported has become available.

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

appropriateness The degree to which service is consistent with requirements and current best practice.

assessment Process by which the characteristics and needs of clients, groups or situations are evaluated or determined so that they can be addressed. The assessment forms the basis of a plan for service or action.

audit A systematic examination and review to determine whether actual activities and results comply with planned arrangements.

authorized individual A term used to describe a physician or other designated health professional defined under relevant legislation as having the ability to request diagnostic tests.

best practice An approach that has been shown to produce superior results, selected by a systematic process, and judged as exemplary, or demonstrated as successful. It is then adapted to fit a particular organization.

cleaning The removal of all foreign material (e.g. soil, organic material) from the surface.

clients A group or an individual who access the services of, or information from the diagnostic facility. Client groups may include referring health-care professionals, the patient's family, community, insurers and other third party payers, employers, and patient advocacy groups.

community Collectivity of individuals, families, groups and organizations that interact with one another, cooperate in common activities and solve mutual concerns, usually in a geographic locality or environment.

competence Guarantee that an individual's knowledge and skills are appropriate to the service provided and assurance that the knowledge and skill levels are regularly evaluated.

complaint Expression of a problem, an issue, or dissatisfaction with services that may be verbal or in writing.

complementary Services or components that fit with each other, or supplement one another, to form more complete services.

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

consent Voluntary agreement or approval given by a client.

continuity The provision of coordinated services within and across programs and organizations, and over time.

contract	Formal agreement that stipulates the terms and conditions for services that are obtained from, or provided to, another organization. The contract and the contracted services are monitored and coordinated by the organization and comply with the standards of the government and the organization.
contracted service provider	Contracted service providers include any vendor, contractor, or supplier that provides services. Examples of contracted service providers could include housekeeping services, preventative maintenance providers, referred out diagnostic services and consultants.
coordination	The process of working together effectively with collaboration among providers, organizations and services in and outside the organization to avoid duplication, gaps, or breaks.
corrected report	A report that is sent when an originally reported result or information in the report has been subsequently found to be incorrect such that a new report is issued. Significant differences in preliminary reports and subsequent reports should be treated as corrected reports.
credentialing	The process of assessing and attesting to an individual's knowledge, skills, and competence and their compliance with specific requirements.
criterion	Specific step to be taken, or activity to be done, to fulfill a standard. In the DAP document, criterion are indicated by a number such as x.1, x.2, x.3…)
criterion descriptor	A specific activity used to rate a criterion.
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.
culture	A shared system of values, beliefs and behaviours.
customers	The patients/clients of a client organization. Internal customers/staff of the organization.
data	Facts from which information can be generated.

decontamination The process of cleaning, followed by the inactivation of pathogenic micro-organisms, in order to render an object safe for handling.

document control system A planned system for controlling the release, change, and use of important documents within the organization, particularly policies and procedures. The system requires each document to have a unique identification, to show dates of issue and updates and authorization. Issue of documents in the organization is controlled and all copies of all documents are readily traceable and obtainable.

education Systematic instructions and learning activities to develop or bring about change in knowledge, attitudes, values or skills.

effectiveness The degree to which services, interventions or actions are provided in accordance with current best practice in order to meet goals and achieve optimal results.

efficiency The degree to which resources are brought together to achieve results with minimal waste, re-work and effort.

ethics Standards of conduct that are morally correct.

evaluation Assessment of the degree of success in meeting the goals and expected results (outcomes) of the organization, services, programs or clients.

evidence Data and information used to make decisions. Evidence can be derived from research, experiential learning, indicator data and evaluations. Evidence is used in a systematic way to evaluate options and make decisions.

follow-up Processes and actions taken after a service has been completed.

form A paper or electronic document which requests services or captures information.

goals Broad statements that describe the outcomes an organization is seeking and provide direction for day-to-day decisions and activities. The goals support the mission of the organization.

governance The function of determining the organization's direction, setting objectives and developing policy to guide the organization in achieving its mission, and monitoring the achievement of those objectives and the implementation of policy.

governing body	Individuals, group or agency with ultimate authority and accountability for the overall strategies directions and modes of operation of the organization. Also known as the council, board, board of commissioners, etc.
guidelines	Principles guiding or directing action.
health professionals	Medical, nursing or allied health professional staff who provide clinical treatment and care to clients, having membership of the appropriate professional body and, where required, having completed and maintained registration or certification from a statutory authority.
human resources	The personnel requirements of the organization.
human resources file	The collection of information about a staff member covering personnel issues such as leave, references, performance appraisals, qualifications, registration and employment terms.
incidents	Events that are unusual, unexpected, may have an element of risk, or that may have a negative effect on clients, groups, staff, or the organization.
indicator	Performance measurement tool, screen or flag that is used as a guide to monitor, evaluate and improve the quality of services. Indicators relate to structure, process and outcomes.
information	Data that is organized, interpreted and used. Information may be in written, audio, video or photograph form.
information systems	Systems for planning, organizing, analyzing and controlling data and information, including both computer-based and manual systems.
leadership	Ability to provide direction and cope with change. It involves establishing a vision, developing strategies for producing the changes needed to implement the vision; aligning people; and motivating and inspiring people to overcome obstacles.
licensure	Process by which a government authority grants permission to an individual practitioner or health-care organization to operate or to engage in an occupation or profession.

management The group or individual responsible for, or the activity of, setting targets or goals for the future through planning and budgeting, establishing processes for achieving those targets and allocating resources to accomplish those plans. Ensuring daily operation of the diagnostic setting. Ensuring that plans are achieved by organizing, staffing, controlling and problem-solving. Management could include directors, managers and department heads as well as charge and chief technical staff.

mandatory A compulsory descriptor identified in the DAP standards. Unfulfilled mandatory descriptors will result in immediate recommendations with specified time frames for follow-up.

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.[2]

method validation The process of proving that an analytical method is acceptable for its intended purposes.

mission A broad written statement in which the organization states what it does and why it exists. The mission sets apart one organization from another.

near miss Is an incident that did not result in injury, illness or damage but had the potential to do so.

near miss An incident that did not result in injury, illness or damage but had the potential to do so.

need Physical, mental, emotional, social or spiritual requirement for well-being. Needs may or may not be perceived or expressed by those in need. They must be distinguished from demands, which are expressed desires, not necessarily needs.

objective A target that must be reached if the organization is to achieve its goals. It is the translation of the goals into specific, concrete terms against which results can be measured.

operational plan The design of strategies, which includes the processes, actions and resources to achieve the goals and objectives of the organization.

organization Comprises all sites/locations under the governance of, and accountable to, the governing body/owner(s).

orientation	The process by which staff become familiar with all aspects of the work environment and their responsibilities.
partners	The organizations that the organization works and collaborates with to provide complementary services.
partnerships	Formal or informal working relationships between organizations where services may be developed and proved jointly, or shared.
peer review	A process whereby the performance of an organization, individuals or groups are evaluated by members of similar organizations or the same profession or discipline and status as those delivering the services.
performance appraisal	The continuous process by which a manager appraisal and a staff member review the staff member's performance, set performance goals, and evaluate progress towards these goals.
philosophy	A statement of principles and beliefs made by the organization by which it is managed and delivers services.
policy	A documented statement of overall intent and direction by those in the organization, endorsed by management.
procedures	Written specified instructions conveying the approved and recommended steps for a particular act or series of acts.
processes	Series of interrelated activities that involve multiple steps or engage multiple people.
qualified	Having the credentials for, being professionally and legally prepared and authorized to perform specific acts.
qualitative	Data and information expressed with descriptions and narratives, a method that investigates the experience of users through observation and interviews.
quality	The degree to which health service for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. (Institute of Medicine)
quality control	The monitoring of output to check if it conforms to specifications or requirements and action taken to rectify the output. Quality control helps to ensure the accuracy and reproducibility of procedures.

quality improvement	A process that seeks to meet client's needs and expectations by using a structured approach to selectively identify areas to improve, and that improves all aspect of the services, including outcomes of service to patients and clients.
quality plan	The current action plan for meeting service quality requirements.
quantitative	Data and information that is expressed in numbers and statistics, a method that investigates phenomena with measures.
recruitment and selection	Processes used to attract, choose and appoint qualified staff and surveyors.
research	A non-diagnostic process which contributes to an existing body of knowledge through investigation, aimed at the discovery and interpretation of facts.
results (outcomes)	The outputs, values, reports and interpretations of tests, procedures or examinations.
rights	Something that can be claimed as justly, fairly, legally or morally one's own. A formal description of the services that clients can expect and demand from an organization.
risk	Chance or possibility of danger, loss or injury. This can relate to the health and well-being of staff and the public, property, reputation, environment, organizational functioning, financial stability, market share and other things of value.
risk management	A systematic process of identifying, assessing and taking action to prevent or manage clinical, administrative, property and occupational health and safety risks in the organization.
safety	The degree to which the potential risk and unintended results are avoided or minimized.

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.
scope	The range and type of services offered by the organization and any conditions or limits to service coverage.
services	Products of the organization delivered to clients, or units of the organization that deliver products to clients.
staff	Individuals who contribute to the delivery of the diagnostic service. This includes both employees of the organization as well as independent contractors.
stakeholder	Individuals, organizations or groups that have an interest or share in services.
standard	An achievable level of performance against which actual performance is compared. In DAP documents standards are identified as whole numbers (i.e. 1.0, 2.0, 3.0…).
strategic plan	A formalized plan that establishes the organization's overall goals and that seeks to position the organization in terms of its environment.
supplier	Suppliers include any vendors that provide goods. Goods are any items purchased such as supplies, equipment, devices or reagents.
survey	External peer assessment which measures the performance of the diagnostic service against an agreed set of standards, criteria and criterion descriptors.
surveyor	External peer reviewer, assessor of diagnostic service performance against agreed standards.
values	Principles, beliefs or statements of philosophy that guide behaviour and that may involve social or ethical issues.
vision	Description of what the organization would like to be.

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