COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

DIAGNOSTIC ACCREDITATION PROGRAM

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EVIDENCE SUBMISSION FOR INITIAL ASSESSMENT

Home Sleep Apnea Testing

Introduction

The home sleep apnea testing (HSAT) facility's evidence submission for initial assessment will be used as part of the assessment process.

The evidence submitted by the facility will be used to assess the criteria and descriptors in the following sections. If additional information is required, you will be contacted by the DAP. The due date for the evidence submission for the initial assessment is included in your notification email.

Instructions

It is **strongly recommended** that the DAP HSAT Accreditation Standards are used in conjunction with the evidence submission form to understand the scope of each request.

1. Review the criteria, descriptors and evidence submission requirements.
2. Gather the evidence.
3. Anonymize any patient identifiers.
4. Label the evidence with the corresponding criteria. For example, when submitting the evidence for HGL1.1.4 in the Governance and Leadership section, ensure that the evidence of an organization chart is clearly labeled with HGL1.1.4.
5. Submit the evidence electronically to dap@cpsbc.ca.

Governance and leadership

Criteria and descriptors (Note: M indicates mandatory)				Evidence submission requirements
HGL1.1	**The governing body/ownership is accountable for the quality and safety of care delivered by the diagnostic service.**			
	HGL1.1.4	**M**	There is a documented and dated organizational chart with clear lines of accountability, responsibility, interrelationships, and authority.	Organizational chart/structure
	HGL1.1.5	**M**	The organization clearly outlines that the services provided by the facility are for the diagnosis and treatment of obstructed sleep apnea.	Copy of facility web page URL
HGL2.1	**The accountability and responsibility for key leadership functions are assigned.**			
	HGL2.1.1	**M**	A medical director (a licensed physician with the College) is appointed with responsibility for the quality and safety of the diagnostic service.	Medical director job description
HGL3.1	**The diagnostic service promotes an environment that fosters and requires ethical and legal behaviour.**			
	HGL3.1.2	**M**	There is a process for addressing unethical or illegal behaviour.	A written code of ethics and a documented process for addressing unethical or illegal behaviour
	HGL3.1.5	**M**	There is a documented mechanism in place to ensure the patient is informed of their right to evaluate equipment treatment options at any location of their choice.	Posted signage or written communication for patients (picture evidence may be submitted)

Medical staff

Criteria and descriptors (Note: M indicates mandatory)			Evidence submission requirements
HMS1.1	**A medical director is appointed with assigned responsibilities and accountabilities for the diagnostic service.**		
	HMS1.1.5 **M**	The medical director must ensure interpreting physicians are credentialed by the College or provide evidence of credentialing by a health authority.	A list of interpreting physicians and their credentials
	HMS1.1.8 **M**	The medical director authorizes the implementation of technical and medical operational policies and procedures related to the diagnostic service.	Documented sign off by the medical director for all policies and procedures
HMS1.3	**The medical director attends the facility to assess the quality and safety of the service.**		
	HMS1.3.1 **M**	The medical director attends the facility to assess and to evaluate it prior to assuming responsibility for the medical directorship of the diagnostic service. *Guidance: It is recommended that the medical director physically visit the facility annually; however, the medical director may assess the facility through virtual means. The virtual assessment must include a video review of the facility.*	A log of the medical director's visit and assessment details of the facility (ensure documentation includes whether the assesment was done on-site or virtually)
HMS1.5	**Roles of authority, responsibility and accountability are clearly defined and maintained at supervised facilities.**		

Criteria and descriptors (Note: M indicates mandatory)				Evidence submission requirements
	HMS1.5.2	**M**	The facility ensures that there is a process in place for interpreting physicians to promptly reply to inquiries about interpreted studies.	A documented process for clinician inquiries by interpreting physicians
HMS2.3	**Home sleep apnea testing is assessed and interpreted by qualified and competent physicians.**			
	HMS2.3.1	**M**	Physicians providing services for adult diagnostic HSAT have the requisite credentials for privileges as outlined in the Provincial Privileging Dictionaries.	Credentialing letter
HMS3.1	**The diagnostic service effectively manages relationships with medical practitioners under contract/agreement.**			
	HMS3.1.1	**M**	There is a documented contract/agreement in place between the medical director and the diagnostic service.	Example of a contract between the diagnostic facility and the medical director (e.g. template of a contract/agreement)
	HMS3.1.2	**M**	There is a documented contract/agreement in place between the interpreting physician(s) and the diagnostic service.	Example of a contract between the diagnostic facility and the interpreting physician(s) (e.g. template of a contract/agreement)

Human resources

Criteria and descriptors (Note: M indicates mandatory)				Evidence submission requirements
HHR1.1	**Human resource planning supports the diagnostic service's goals and objectives.**			
	HHR1.1.3	**M**	Job descriptions that reflect current practice, certification or registration and position responsibilities are available for all staff.	Job descriptions for all staff (e.g. supervisor, manager, therapist, administrative staff)
	HHR1.1.6	**M**	There is a process for staff to bring forward concerns/complaints and for the diagnostic service leadership to respond in a fair, objective and timely manner.	Documented process for staff concerns/complaints Example of a complaint form
HHR2.2	**Diagnostic HSAT sleep services are provided by registered polysomnographic technologist (RPSGT) who are qualified and competent.**			
	HHR2.2.1	**M**	RSPGT staff providing HSAT services are certified by the Board of Registered Polysomnographic Technologists (BRPT).	A list of staff that perform HSAT duties and their qualifications
HHR3.1	**Staff receive orientation and training for the administration of HSAT devices to ensure patient safety and collection of accurate data.**			
	HHR3.1.1	**M**	Staff receive training for the equipment operation, application of sensors, use, maintenance, warnings and safety.	Orientation and training manual Staff competency checklists
	HHR3.1.2	**M**	Staff receive training on patient instructions.	Orientation and training manual
	HHR3.1.3	**M**	Staff receive training on troubleshooting of the HSAT device.	Orientation and training manual

Criteria and descriptors (Note: M indicates mandatory)				Evidence submission requirements
	HHR3.1.4	**M**	Staff receive training in infection prevention and control procedures (e.g. cleaning and disinfection).	Orientation and training manual
	HHR3.1.5	**M**	Staff receive training on procedures for a patient to contact them if they experience problems with the HSAT exam.	Orientation and training manual
HHR3.2	**HSAT scoring is conducted in a manner that ensures accurate data for interpretation and diagnosis.**			
	HHR3.2.1	**M**	Scoring of studies is conducted or supervised by registered polysomnographic technologist (RPSGT) staff.	A list of scoring staff and their qualifications (ensure details include who provides supervision for non-RPSGT)
HHR3.2	**HSAT scoring is conducted in a manner that ensures accurate data for interpretation and diagnosis.**			
	HHR3.2.3	**M**	Outsourced scoring services must be conducted by a RPSGT, located in Canada, have a QA program in place, and be approved by the medical director.	Name and contact of the outsourced scoring service Documented sign-off by the medical director
HHR4.1	**Orientation and training for the safe provision of quality diagnostic services are provided.**			
	HHR4.1.1	**M**	Staff receive orientation and training to address adverse events and critical incident reporting.	Orientation and training manual
	HHR4.1.7	**M**	Staff receive orientation and training to address medical emergency procedures (e.g. cardiac arrest).	Orientation and training manual

Criteria and descriptors (Note: M indicates mandatory)			Evidence submission requirements
	HHR4.1.11 **M**	Staff receive orientation and training to cleaning and disinfection procedures for medical devices.	Orientation and training manual

Patient and client focus

Criteria and descriptors (Note: M indicates mandatory)			Evidence submission requirements
HPC2.1	**There is a process in place to gather feedback and follow-up on patient complaints.**		
	HPC2.1.2 **M**	There is a procedure for documenting complaints from patients and clients.	A documented process for collecting concerns/complaints Example of a complaint form

General safety

Criteria and descriptors (Note: M indicates mandatory)			Evidence submission requirements
HSA1.1	**Potential hazards and risks to staff, patients and visitors are minimized.**		
	HSA1.1.2 **M**	Regular inspections of the work area, equipment, and practices are performed at a defined interval as determined by the facility to identify and resolve safety hazards.	A procedure for regular inspections for the work area, equipment and practices Example of a workplace inspection report
	HSA1.1.4 **M**	There is a basic first aid kit available.	Evidence of a first aid kit and its location (photo evidence may be submitted)

Criteria and descriptors (Note: M indicates mandatory)				Evidence submission requirements
	HSA1.1.6	**M**	There are procedures to protect staff working alone or in isolation.	Working alone policy
HSA1.2	**The diagnostic service is prepared for disasters and emergencies.**			
	HSA1.2.2	**M**	There are procedures for responding to medical emergencies.	Policies and procedures addressing adverse events and critical incidents (e.g. reporting, investigating, implementation of corrective actions)
	HSA 1.2.1	**M**	Emergency exit routes are marked and provide an unimpeded exit.	Facility floor plan Picture of storefront
	HSA1.2.4	**M**	Emergency instructions are posted in the office for easy reference.	Emergency evacuation instructions (photo evidence may be submitted)
HSA1.3	**Chemicals are used, stored and disposed of safely.**			
	HSA1.3.2	**M**	MSDS are available and current for controlled substances subject to Workplace Hazardous Materials Information System (WHMIS).	A list of MSDS for controlled substances

Patient safety

Criteria and descriptors (Note: M indicates mandatory)				Evidence submission requirements
HPS1.1	**The diagnostic service creates a culture to ensure that patient safety is a priority.**			
	HPS1.1.1	**M**	Mechanisms are in place to address patient sensitivities and allergies.	Documented procedure to identify patient sensitivities and allergies

Infection prevention control

Criteria and descriptors (Note: M indicates mandatory)			Evidence submission requirements
HIPC1.1	**Planning for infection prevention and control is effective, integrated and coordinated.**		
	HIPC1.1.1	**M** There are documented procedures for infection prevention and control.	Infection prevention and control manual
HIPC2.1	**The diagnostic service reduces the risk of infections associated with medical devices.**		
	HIPC2.1.2	**M** Staff assigned to reprocessing medical devices have completed training in reprocessing.	Orientation and training manual
HIPC2.3	**When only multi-use reusable medical devices are available for diagnostic or treatment purposes standardized reprocessing practices are implemented.**		
	HIPC2.3.2	**M** If reprocessing reusable semi-critical medical devices then only HLD by pasteurization or sterilization can be used, provided it is validated by the manufacturer.	Procedure for reprocessing reusable semi-critical medical devices Copy of the manufacturer's recommendations for reprocessing Note: This criteria may be N/A if no reprocessing of semi-critical devices is conducted.

Information management

Criteria and descriptors (Note: M indicates mandatory)				Evidence submission requirements
HIM2.1	**The diagnostic service retains documents and records.**			
	HIM2.1.1	**M**	Medical records are stored according to the British Columbia's *Limitation Act*.	Documented procedure for the storage of medical records
HIM2.3	**The diagnostic service ensures that the integrity of the data is maintained and is readily available.**			
	HIM2.3.1	**M**	For computerized systems, database back-up is performed daily and the backup is securely located in a separate physical location.	Documented procedure for database backup including the location of where the data is stored
HIM3.1	**The diagnostic service protects the confidentiality of data and information.**			
	HIM3.1.3	**M**	There is a policy for the use and disclosure of personal information.	Documented policy for use and disclosure of personal information

Equipment and supplies

Criteria and descriptors (Note: M indicates mandatory)				Evidence submission requirements
HES1.1	**Equipment is safely operated, maintained, and monitored in a manner that ensures performance specifications are met.**			
	HES1.1.2	**M**	An orientation and training program is provided for all equipment to ensure safe, consistent, and accurate operation.	Orientation and training manual
HES1.2	**Equipment testing is performed prior to clinical use.**			
	HES1.2.1	**M**	New equipment is evaluated by a qualified individual prior to clinical use.	Documented procedure for evaluating new equipment Training records for qualified staff
	HES1.2.6	**M**	There is a record that new or refurbished equipment has been authorized for use by a qualified individual.	Record of the evaluated equipment

Global HSAT

Criteria and descriptors (Note: M indicates mandatory)			Evidence submission requirements
HG1.1	**Test requests are standardized and ensure that accurate, comprehensive, and appropriate information is relayed.**		
	HG1.1.4	**M** Processes are in place to assess test appropriateness. *Intent: Test appropriateness is evaluated by the medical director or qualified designate prior to testing. The medical director is available to the designate, if required.*	Documented procedure for evaluating test appropriateness Additional documentation, if conducted by a designate (e.g. sign-off by the medical director for the qualified designate)
HG3.1	**Standardized procedures are used in diagnostic facilities to obtain test results.**		
	HG3.1.1	**M** All procedures are documented, communicated to, and available to staff performing the testing.	Procedural manual
HG5.0	**Interpretation and Reports**		
	HG5.1	**M** Diagnostic reports are labeled in a standardized format that provides comprehensive and necessary information for clinical decision-making.	Example of a report template Note: Report format includes all the criteria under the interpretation and report section of the accreditation standards.
HG5.4	**Urgent and other non-routine test findings are effectively communicated.**		
	HG5.4.1	**M** There is a written procedure on communication of urgent and other non-routine tests findings (e.g. critical findings/results).	Documented procedure for communicating urgent and other non-routine tests findings

HSAT

Criteria and descriptors (Note: M indicates mandatory)			Evidence submission requirements
HSAT2.3	**Analysis of test data is conducted in a way that ensures meaningful, relevant, and accurate data are reported.**		
	HSAT2.3.1 **M**	HSAT data is scored manually by a RPSGT.	Documented policy indicating that all HSAT studies are to be manually scored by qualified staff
HSAT2.5	**Technical summary is standardized in a way that ensures meaningful, relevant, and accurate data are reported.**		
	HSAT2.5.1 **M**	Type of recording device.	A list of recording device(s) used by facility
HSAT3.1	**PAP protocols are standardized in a manner that ensures appropriate patient therapy.**		
	HSAT3.1.4 **M**	There is a documented protocol for patient follow-up.	Documented procedure for patient follow-up